Avian Influenza A (H5N1) Case Report Form

State:_____ Date reported to health department:___/___/_____(MM/DD/YYYY) Date interview completed:___/___/_____(MM/DD/YYYY)

State Epi ID:_____ State Lab ID: _____

Final case classification:

☐ Confirmed ☐ Probable ☐ Suspect

Demographic Information

1. Date of birth:_____/_____/_____(MM/DD/YYYY)
2. Country of usual residence:_____
3. Primary language spoken: _____
4. Race: (check all that apply) ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Native Hawaiian/Other Pacific Islander
5. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
6. What is your current gender identity? (Select all that apply)

   ☐ Woman/Female ☐ Transgender Woman/Female ☐ Two-spirit (a term used by some AIAN individuals) ☐ Non-Binary

   ☐ Man/Male ☐ Transgender Man/Male ☐ Genderqueer ☐ Agender ☐ Questioning
7. What sex were you assigned at birth, on your original birth certificate? (select one) ☐ Female ☐ Male ☐ My sex is not listed on my original birth certificate
8. Occupation: _____ If farmworker, list specific job duties (e.g., milks cows): _____

Symptoms, Clinical Course, Treatment, Testing, and Outcome

9. What date did symptoms associated with this illness start?_____/_____/_____(MM/DD/YYYY)
10. During this illness, did the patient experience any of the following?

Symptom	Symptom Present?	Symptom	Symptom Present?
Fever (highest temp_____ºF)	☐ Yes ☐ No ☐ Unk	Shortness of breath	☐ Yes ☐ No ☐ Unk
If fever present, date of onset	/ / (MM/DD/YYYY)	Vomiting	☐ Yes ☐ No ☐ Unk
Felt feverish	☐ Yes ☐ No ☐ Unk	Diarrhea	☐ Yes ☐ No ☐ Unk
If felt feverish, date of onset	/ / (MM/DD/YYYY)	Eye infection/redness	☐ Yes ☐ No ☐ Unk
Cough	☐ Yes ☐ No ☐ Unk	Rash	☐ Yes ☐ No ☐ Unk
Sore Throat	☐ Yes ☐ No ☐ Unk	Fatigue	☐ Yes ☐ No ☐ Unk
Muscle aches	☐ Yes ☐ No ☐ Unk	Seizures	☐ Yes ☐ No ☐ Unk
Headache	☐ Yes ☐ No ☐ Unk	Other, specify	

11. Did the patient receive any medical care for the illness?

    ☐ Yes ☐ No ☐ Unknown
12. If yes, where and on what date did the patient seek care (check all that apply)?

    ☐ Doctor's office **date**:_____/_____/_____(MM/DD/YYYY) ☐ Emergency room **date**:_____/_____/_____(MM/DD/YYYY)
    ☐ Urgent care clinic **date**:_____/_____/_____(MM/DD/YYYY))

    ☐ Other, eg, local health department_____**date**:_____/ /_____(MM/DD/YYYY) ☐ Unknown

    Is this where H5 positive swab was collected? ☐ Yes ☐ No
13. Was the patient hospitalized for the illness? **If yes, please complete "Hospitalized Patient Module"** (Q.64)

    ☐ Yes ☐ No ☐ Unknown

14. Did the patient receive influenza antiviral medications?

☐ Yes, (please complete table below) ☐ No ☐ Unknown

Drug	Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)	Total number of days receiving antivirals	Dosage (if known)
Oseltamivir (Tamiflu)				mg
Zanamivir (Relenza)				mg
Peramivir (Rapivab)				mg
Other influenza antiviral_____				mg

15. Did the patient die as a result of this illness?

☐ Yes, **Date of death**:____/____/____(MM/DD/YYYY) ☐ No ☐ Unknown

Influenza Test

Date of Specimen Collection	Test type (e.g. Rapid, PCR)	Specimen type (e.g. conjunctival, NP)	Test Result (e.g. Influenza A (initial), H5N1 (subtype)	Lab (e.g. CDC vs CA PHL)

Medical History - Past Medical History and Vaccination Status

16. Does the patient have any of the following chronic medical conditions? Please specify **ALL** conditions that qualify.

a. Asthma/reactive airway disease ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____
b. Other chronic lung disease ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____
c. Chronic heart or circulatory disease ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____
d. Diabetes mellitus ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____
e. Kidney or renal disease ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____
f. Non-cancer immunosuppressive condition ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____
g. Cancer chemotherapy in past 12 months ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____
h. Neurologic/neurodevelopmental disorder ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____
i. Other chronic diseases ☐ Yes ☐ No ☐ Unknown (If YES, specify) _____

17. Was patient pregnant or ≤6 weeks postpartum at illness onset?

☐ Yes, pregnant (weeks pregnant at onset)_____ Yes, postpartum (delivery date)_____/_____/_____(MM/DD/YYYY)
☐ No ☐ Unknown

18. Does the patient currently smoke or vape?

☐ Yes ☐ No ☐ Unknown If yes, specify_____

19. Was the patient vaccinated against seasonal influenza in the past year? ☐ Yes ☐ No (skip to Q.21) ☐ Unknown (skip to Q.21)

20. Month and year of seasonal influenza vaccination? **Vaccination date 1:**__/____(MM/YYYY) **Vaccination date 2:** ____/____(MM/YYYY)
(Only previously unvaccinated children <9 years of age are recommended to receive two doses of seasonal influenza vaccine in one season)

If yes, type of influenza vaccine (check all that apply) ☐ Inactivated (injection) ☐ Live attenuated (nasal spray) ☐ Other _____

☐ Unknown

Epidemiologic Risk Factors

21. In the 10 days prior to illness onset, did the patient travel outside of his/her usual area?

☐ Yes ☐ No (skip to Q.24) ☐ Unknown (skip to Q.24)

22. When and where did the patient travel? **Please describe details of the patient's travel in the notes section at the end of the form.**

Trip 1: Dates of travel: / / to / / Country State City/County

Trip 2: Dates of travel: / / to / / Country State City/County

23. Did the patient travel in a group (check all that apply)?

☐ No, travelled alone ☐ Yes, with household members ☐ Yes, with non-household members ☐ Unknown

Please describe the details of the trip

_____

_____

_____

24. In the 10 days prior to illness onset, did the patient attend a public event where a large number of people were present (e.g., a sporting event, wedding, concert)? ☐ Yes ☐ No ☐ Unknown

Please describe the event (include date and location)

_____

_____

_____

25. In the 10 days prior to illness onset, or at any time after illness onset, did the patient travel by means of public conveyance where others were present (e.g., public bus or train)? ☐ Yes ☐ No ☐ Unknown

Please describe means and frequency of public travel

_____

_____

_____

26. In the 10 days prior to illness onset, did the patient have close contact with someone who travelled outside the United States?
☐ Yes ☐ No ☐ Unknown

Please describe individual (including travel location)

_____

_____

_____

Risk Factors – Animal and Animal Product Exposure

27. In the 10 days before becoming ill, did the patient have **direct or any other** contact with animals?

☐ Yes (specify animal type and location_____) ☐ No ☐ Unknown

28. In the 10 days before becoming ill, did the patient have **direct or any other** contact with any animal suspected or confirmed to be influenza A (H5N1) positive? ☐ Yes (specify animal type and location_____)

☐ Wild birds (answer Animal Exposure - **module A**) ☐ Poultry (chickens, turkeys, ducks, or geese, etc.) (answer Animal Exposure - **module A**)

☐ Livestock (cattle, goats, sheep, pigs, etc.) (answer Animal Exposure - **module B**)

29. In the 10 days before becoming ill, did the patient consume any raw or unpasteurized milk or milk products from a cow or other animal sources, including drinking milk on the farm where it was produced or drinking milk from the "bulk tank"?

☐ Raw milk ☐ Raw milk cheese ☐ Heavy raw cream ☐ Whole raw kefir ☐ Raw butter ☐ Raw yogurt

☐ Raw kefir pet food ☐ Raw milk pet food ☐ Other (specify): _____ ☐ Unknown ☐ Refused

(If *yes* ask sub-questions *a* through *g*, write in "Refused" if refused to answer or "NA" if question not applicable)

a. What type of milk (cow milk, goat milk, etc.), variety, and brand: _____ ☐ Unknown

b. What was the first date of consumption in the 10 days before becoming ill (MM-DD-YYY): _____ ☐ Unknown

c. Where was the milk acquired (store name, farm name, herd share, etc.): _____ ☐ Unknown

d. What was the address, city, and state of acquisition (if not case's home): ☐ Unknown

e. What was the product expiration/best by/best before date: ☐ Unknown

f. What was the product lot number or code on the packaging:_____ ☐ Unknown

g. Is there any remaining product? ☐ Yes ☐ No ☐ Unknown

30. Did the patient have exposure to any eggs from a private flock (i.e., not store bought or commercial) in the 10 days before becoming ill?

☐ Yes ☐ No ☐ Unknown

31. Did the patient consume raw or undercooked poultry in the 10 days before becoming ill?

☐ Yes ☐ No ☐ Unknown

Risk Factors – Household, Occupational, Nosocomial, and Secondary Spread

32. Does the patient reside in an institutional or group setting (e.g. nursing home, boarding school, college dormitory)

☐ Yes ☐ No ☐ Unknown

33. How many people resided in the patient's household(s) in the week before or after illness onset (excluding the patient)? _____

A household member is anyone with at least one overnight stay +/- 7 days from patient's illness onset. The patient may have resided in >1 household during this time. Please complete the table below for each household member and continue in the notes section if more space is needed.

ID	Household (HH) ["A" should be the patient's primary household]	Relation to patient (e.g. parent, brother, friend)	Sex (M/F)	Age	Was HH member ill (fever or any respiratory symptom) +/– 7 days from case patient's onset?	If Yes, HH member's date of illness onset
1	☐A ☐B ☐C				☐Y ☐N ☐U	
2	☐A ☐B ☐C				☐Y ☐N ☐U	
3	☐A ☐B ☐C				☐Y ☐N ☐U	
4	☐A ☐B ☐C				☐Y ☐N ☐U	
5	☐A ☐B ☐C				☐Y ☐N ☐U	
6	☐A ☐B ☐C				☐Y ☐N ☐U	

34. In the 7 days before or after becoming ill, did the patient attend or work at a childcare facility?

☐ Yes (before becoming ill) ☐ Yes (after becoming ill) ☐ No (skip to Q.36) ☐ Unknown (skip to Q.36)

35. Approximately how many children are in the patient's class or room at the childcare facility? _____

36. In the 7 days before or after becoming ill, did the patient attend or work at a school?

☐ Yes (before becoming ill) ☐ Yes (after becoming ill) ☐ No (skip to Q.38) ☐ Unknown (skip to Q.38)

37. Approximately how many students are in the patient's class at the school?_____

38. In the 7 days before or after the patient became ill, did anyone else in the patient's household(s) work at or attend a childcare facility or school?

☐ Yes ☐ No (skip to Q.40) ☐ Unknown (skip to Q.40)

39. List ID numbers from Q.33 (the table above) for household members working at or attending a childcare facility or school:

_____

40. Does the patient handle samples (animal or human) suspected of containing influenza virus in a laboratory or other setting?

☐ Yes ☐ No ☐ Unknown

41. In the 7 days before or after becoming ill, did the patient work in or volunteer at a healthcare facility or setting?

☐ Yes ☐ No (skip to Q.44) ☐ Unknown (skip to Q.44)

42. Specify healthcare facility job/role:

☐ Physician ☐ Nurse ☐ Administration staff ☐ Housekeeping ☐ Patient transport ☐ Volunteer ☐ Other_____

43. Did the patient have direct patient contact while working or volunteering at a healthcare facility?
☐ Yes ☐ No ☐ Unknown

44. In the 7 days before becoming ill, was the patient in a hospital for any reason (i.e., visiting, working, or for treatment)?
☐ Yes ☐ No ☐ Unknown

If yes, what were the dates? ___/___/___, ___/___/___ City/Town _____

45. In the 7 days before becoming ill, was the patient in a clinic or a doctor's office for any reason?
☐ Yes ☐ No ☐ Unknown

If yes, what were the dates? ___/___/___, ___/___/___ City/Town _____

46. Does the patient know anyone **other than a household member** who had fever, respiratory symptoms like cough or sore throat, or another respiratory illness like pneumonia in the 7 days **BEFORE** the case patient's illness onset?

☐ Yes (please list those ill before the case patient in the table below) ☐ No ☐ Unknown

ID	Relationship to patient	Sex (M/F)	Age	Date of illness onset	Comments
1					
2					
3					
4					

47. Does the patient know anyone **other than a household member** who had fever, respiratory symptoms like cough or sore throat, or another respiratory illness like pneumonia beginning **AFTER** the case patient's illness onset?

☐ Yes (please list those ill after the case patient in the table below) ☐ No ☐ Unknown

ID	Relationship to patient	Sex (M/F)	Age	Date of illness onset	Comments
1					
2					
3					
4					

48. Is the patient a contact of a confirmed or probable case of novel influenza A infection?
☐ Yes (please list patient's confirmed or probable contacts in the table below) ☐ No ☐ Unknown

Relationship to patient	State Epi ID	State Lab ID	Case status	Sex (M/F)	Age	Date of illness onset (MM/DD/YYYY)
			☐ Confirmed ☐ Probable			
			☐ Confirmed ☐ Probable			
			☐ Confirmed ☐ Probable			
			☐ Confirmed ☐ Probable			

49. Any additional comments or notes (e.g. travel details, names/dates of fairs or live markets attended by case patient, dates of household members fair attendance and location of fair, information about other ill contacts)

Animal Exposure Questions

Module A - Wild birds or poultry (chickens, turkeys, ducks, or geese, etc.)

50. Where did the direct contact or exposures to birds occur (check all that apply)?

☐ Home ☐ Commercial poultry farm ☐ Agricultural fair or event ☐ Live animal market ☐ Petting zoo
☐ Veterinary care ☐ Slaughterhouse/Rendering facility ☐ Other _____ Farm Name/CDFA ID: _____

51. Did the patient participate in the culling of any poultry flocks?

☐ Yes ☐ No ☐ Unknown

52. What measures did the patient use to protect himself/herself during the culling (check all that apply)?

☐ None ☐ Facemask ☐ Respirators ☐ Hand gloves ☐ Goggles ☐ Face shield ☐ Gowns

☐ Boot ☐ Unknown ☐ Other_____ If PPE was not used, please explain why _____

53. What percentage of time did the person participating in culling wear the items mentioned above while culling flocks (*only ask about the items the exposed person mentioned in Q.52*)? ☐ Never ☐ Rarely ☐ Sometimes ☐ Always

54. Did the patient report **direct or any other** exposure (direct, or any other exposure, or both) with any **ill-appearing poultry** in the 10 days before becoming ill? ☐ Yes, specify ☐ No ☐ Unknown

55. Did the patient report **direct or any other** exposure (direct, or any other exposure, or both) with **dead poultry** in the 10 days before becoming ill?
☐ Yes, specify_____ ☐ No (skip to end) ☐ Unknown

Module B – Livestock (cattle, sheep, goats, pigs, etc.)

56. Where did the **direct** contact with livestock occur (check all that apply)?

☐ Home ☐ Commercial farm ☐ Agricultural fair or event ☐ Live animal market ☐ Petting zoo ☐ Veterinary care

☐ Slaughterhouse/rendering facility ☐ Other Farm Name/CDFA ID: _____

57. What type(s) of livestock did the patient have **direct** contact with (check all apply)?

☐ Cattle ☐ Sheep ☐ Goats

58. Did the patient conduct any of the following activities in the 10 days before becoming ill (check all that apply)?

☐ Work at a farm or facility where live animals are present ☐ Touch, handle, or otherwise interact with ill livestock (cattle, goats, sheep)

☐ Touch, handle, or otherwise interact with ill wild animals ☐ Work in a maternity or reproductive area of a farm

☐ Handle or clean up animal stool or manure ☐ Use a pressure washer or broom in an area contaminated by animal manure or milk

☐ Operate or clean automated milking equipment ☐ Perform manual milking of animals

59. What measures did the patient use to protect himself/herself when exposed to livestock (check all that apply)?

☐ None ☐ Facemask ☐ Respirators ☐ Hand gloves ☐ Goggles ☐ Face shield ☐ Gowns ☐ Boot

☐ Unknown ☐ Other_____

60. What percentage of time did the person wear the items mentioned above while exposed to livestock (*only ask about the items the exposed person mentioned in Q. 60*)? ☐ Never ☐ Rarely ☐ Sometimes ☐ Always

61. Did the patient report **direct or any other** exposure to any **livestock that appeared ill** in the 10 days before becoming ill?

☐ Yes, specify_____ ☐ No ☐ Unknown

62. Did the patient report **direct or any other** exposure to **dead livestock** in the 10 days before becoming ill?

☐ Yes, specific ☐ No ☐ Unknown

Hospitalized Patient Module

63. Date(s) of hospital admission? **First admission date:** ____/__/____(MM/DD/YYYY) **Second admission date:**___/___/____(MM/DD/YYYY)

64. Was the patient admitted to an intensive care unit (ICU)?

☐ Yes ☐ No ☐ Unknown

Date of **ICU admission:**_____/____/_____ (MM/DD/YYYY) Date of **ICU discharge:**___/___/_____ (MM/DD/YYYY)

65. Did the patient receive mechanical ventilation / have a breathing tube?

☐ Yes ☐ No ☐ Unknown

66. If yes, how many days did the patient receive mechanical ventilation or have a breathing tube?_____

Did the patient receive ECMO? ☐ Yes ☐ No ☐ Unknown

If yes, how many days did the patient receive ECMO? _____

67. Was the patient discharged alive?

☐ Yes ☐ No ☐ Unknown

68. Date(s) of hospital discharge? **First discharge date:**___/___/____(MM/DD/YYYY) **Second discharge date:**___/___/____(MM/DD/YYYY)

69. Where was the patient discharged to?

☐ Home ☐ Nursing facility/rehab ☐ Hospice ☐ Other_____ ☐ Unknown

70. Did the patient have a new abnormality on chest x-ray or CT scan?

☐ No, x-ray or scan was normal ☐ Yes, x-ray or scan detected new abnormality ☐ No, x-ray or CT scan not performed ☐ Unknown

71. Did the patient receive a diagnosis of pneumonia?

☐ Yes ☐ No ☐ Unknown

72. Did the patient receive a diagnosis of ARDS?

☐ Yes ☐ No ☐ Unknown

73. Did the patient have leukopenia (white blood cell count <5000 leukocytes/mm^3) associated with this illness?

☐ Yes ☐ No ☐ Test not performed ☐ Unknown

74. Did the patient have lymphopenia (total lymphocytes <800/mm^3 or lymphocytes <15% of WBC) associated with this illness?

☐ Yes ☐ No ☐ Test not performed ☐ Unknown

75. Did the patient have thrombocytopenia (total platelets <150,000/mm^3) associated with this illness?

☐ Yes ☐ No ☐ Test not performed ☐ Unknown

76. Did the patient experience any other complications as a result of this illness?

☐ Yes (please describe below) ☐ No ☐ Unknown

_____

_____