



SWINE-ORIGIN INFLUENZA A (H1N1) VIRUS CASE REPORT

REPORT INFORMATION

Reported by: County/City _____ Date reported ____/____/____

At the time of report, the case is PROBABLE (Influenza A unsubtypeable) CONFIRMED Date of confirmation ____/____/____

PATIENT DEMOGRAPHICS

Patient name—last	first	middle initial	Date of birth ____/____/____	Age (enter age and check one) ____ <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address—number, street			City	State	ZIP code
Home telephone number ()		Work telephone number ()	Cell number ()	Email:	
ETHNICITY (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown		RACE (check all that apply) <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		<input type="checkbox"/> Asian: Please specify: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Hmong <input type="checkbox"/> Thai <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other Asian: _____ <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian _____	
<input type="checkbox"/> Pacific Islander: Please specify: <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander: _____		Country of birth	Country of residence	Primary language spoken in home	Does someone in home speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

LHD CASE TRACKING AND INVESTIGATOR CONTACT DATA

County case number	CDPH Case ID Number	
Case investigator completing form	Investigator telephone ()	Investigator's jurisdiction
Investigator email	Investigator fax ()	

SIGNS AND SYMPTOMS

Date of symptom onset ____/____/____	Fever>37.8 C (100F) max <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Feverish but temp not taken <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Conjunctivitis (eye infection) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sore throat <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Rhinorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Headache <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Body/muscle aches <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Describe other symptoms	

HOSPITALIZATIONS, COMPLICATIONS AND UNDERLYING MEDICAL CONDITIONS

Hospitalized* <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name of Hospital	Admit Date	Discharge Date	ICU <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Asthma / chronic lung disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Heart or circulatory disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Metabolic disease (e.g. diabetes) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cancer in last 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other underlying medical conditions If yes, specify <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Compromised immune system? (e.g., HIV, cancer, chronic corticosteroid?) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify:		
Death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, date of death ____/____/____	*If patient was hospitalized, please obtain hospital medical record	Hospital medical record number	

LABORATORY TESTS AND RESULTS

LHD lab id number (1)	LHD lab id number (2)	Rapid Flu A positive at LHD lab? <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done <input type="checkbox"/> Unk		
Specimen collection date ____/____/____	Specimen collection date ____/____/____	Rapid Flu A positive at state lab? <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done <input type="checkbox"/> Unk		
State lab id number (1)	State lab id number (2)	Rapid Flu A positive at state lab? <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done <input type="checkbox"/> Unk		
Specimen collection date ____/____/____	Specimen collection date ____/____/____	Rapid Flu A positive at state lab? <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done <input type="checkbox"/> Unk		
RT-PCR Flu A positive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Unsubtypeable Flu A positive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Lab-confirmed Swine H1 at local lab? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Lab-confirmed Swine H1 at state lab? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Lab confirmed Swine H1 at CDC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

VACCINATION/ANTIVIRAL MEDICATION HISTORY

Was the patient vaccinated against seasonal influenza in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did the patient receive antiviral medications? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
--	---

EPIDEMIOLOGICAL EXPOSURE - 7 DAYS BEFORE ONSET THROUGH 7 DAYS AFTER ONSET

Setting (check all that apply)

1 <input type="checkbox"/> Day care	4 <input type="checkbox"/> Hospital Ward	7 <input type="checkbox"/> Home	10 <input type="checkbox"/> College	13 <input type="checkbox"/> Religious Facility
2 <input type="checkbox"/> School	5 <input type="checkbox"/> Hospital ER	8 <input type="checkbox"/> Work	11 <input type="checkbox"/> Military	14 <input type="checkbox"/> International travel
3 <input type="checkbox"/> Doctor's office	6 <input type="checkbox"/> Outpatient hospital clinic	9 <input type="checkbox"/> Unknown	12 <input type="checkbox"/> Correctional facility	
15 <input type="checkbox"/> Other (specify) _____				

Name of setting(s) if applicable (schools, hospital, correctional facility, day care, etc):

Outbreak or cluster related <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Outbreak or cluster name or location
--	--------------------------------------

Number of household members including this case-patient:	Did the case-patient have close contact (within 2 meters or 6 feet) with a person who is a confirmed swine influenza case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did case-patient travel to Mexico in the 7 days prior to symptom onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
--	---	--

Does the case-patient work in a health care facility or setting? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, name of facility: _____	Does case-patient have direct patient care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

Did this case- patient seek medical care (other than hospital)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, name of facility: _____	If yes, Date of medical visit ____ / ____ / ____
--	---

Does the case-patient attend or work at a school or day care?
 Yes No Unknown If yes, name of facility: _____

Last date case-patient attended or worked at day care or school ____ / ____ / ____	Did the school close? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of school/day care closure ____ / ____ / ____
---	--	---

Does case-patient live in institution or other congregate setting? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, type of setting <input type="checkbox"/> Dormitory <input type="checkbox"/> Long-term care facility <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Homeless shelter <input type="checkbox"/> Other specify: _____
---	---

Did case-patient travel on an airplane during his/her illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, Date(s) of flight(s)	Airline(s)	Flight # (s)
---	------------------------------	------------	--------------

CONTACT TRACING AND SOCIAL MANAGEMENT

TIMELINE OF INFECTIOUSNESS

WEEK	Infectious Period (day -1 to day +7)														F/U HH contacts		
	Exposure/Incubation Period							Onset day									
	-7	-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6	+7	+8	+14
Enter dates																	

(if obtained) Date acute blood collected (within first 7 days of disease onset) ____ / ____ / ____	Date convalescent blood collected (2-3 weeks after symptom onset) ____ / ____ / ____
--	---

REMARKS