



# Influenza, Novel

County \_\_\_\_\_

Case name (last, first) \_\_\_\_\_

Birth date \_\_\_/\_\_\_/\_\_\_ Age at symptom onset \_\_\_\_\_  Years  Months

Alternate name \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Address type  Home  Mailing  Other  Temporary  Work

Street address \_\_\_\_\_

City/State/Zip/County \_\_\_\_\_

Residence type (incl. Homeless) \_\_\_\_\_ WA resident  Yes  No

## ADMINISTRATIVE

Investigator \_\_\_\_\_ LHM Case ID (optional) \_\_\_\_\_

LHM notification date \_\_\_/\_\_\_/\_\_\_

### Classification

Classification pending  Confirmed  Investigation in progress  Not reportable  Probable  Ruled out  Suspect

### Investigation status

Complete  Complete – not reportable to DOH  Unable to complete Reason \_\_\_\_\_  In progress

Dates: Investigation start \_\_\_/\_\_\_/\_\_\_ Investigation complete \_\_\_/\_\_\_/\_\_\_ Record complete \_\_\_/\_\_\_/\_\_\_ Case complete \_\_\_/\_\_\_/\_\_\_

## REPORT SOURCE

Initial report source \_\_\_\_\_ LHM \_\_\_\_\_

Reporter organization \_\_\_\_\_

Reporter name \_\_\_\_\_ Reporter phone \_\_\_\_\_

All reporting sources (list all that apply) \_\_\_\_\_

## DEMOGRAPHICS

Sex at birth:  Female  Male  Other  Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

**Ethnicity**  Hispanic, Latino/a, Latinx  Non-Hispanic, Latino/a, Latinx  Patient declined to respond  Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

**Race**  Amer Ind/AK Native (**specify:**  Amer Ind **and/or**  AK Native)  Asian  Black or African American  Native HI/Pacific Islander (**specify:**  Native HI **and/or**  Pacific Islander)  White  Patient declined to respond  Unk

Additional race information:

- Afghan  Afro-Caribbean  Arab  Asian Indian  Bamar/Burman/Burmese  Bangladeshi  Bhutanese
- Central American  Cham  Chicano/a or Chicanx  Chinese  Congolese  Cuban  Dominican  Egyptian
- Eritrean  Ethiopian  Fijian  Filipino  First Nations  Guamanian or Chamorro  Hmong/Mong
- Indigenous-Latino/a or Indigenous-Latinx  Indonesian  Iranian  Iraqi  Japanese  Jordanian  Karen
- Kenyan  Khmer/Cambodian  Korean  Kuwaiti  Lao  Lebanese  Malaysian  Marshallese  Mestizo
- Mexican/Mexican American  Middle Eastern  Mien  Moroccan  Nepalese  North African  Oromo
- Pakistani  Puerto Rican  Romanian/Rumanian  Russian  Samoan  Saudi Arabian  Somali
- South African  South American  Syrian  Taiwanese  Thai  Tongan  Ugandan  Ukrainian
- Vietnamese  Yemeni  Other: \_\_\_\_\_

What is your (your child's) preferred language? Check one:

- Amharic  Arabic  Balochi/Baluchi  Burmese  Cantonese  Chinese (unspecified)  Chamorro  Chuukese
- Dari  English  Farsi/Persian  Fijian  Filipino/Pilipino  French  German  Hindi  Hmong  Japanese
- Karen  Khmer/Cambodian  Kinyarwanda  Korean  Kosraean  Lao  Mandarin  Marshallese  Mixteco
- Nepali  Oromo  Panjabi/Punjabi  Pashto  Portuguese  Romanian/Rumanian  Russian  Samoan
- Sign languages  Somali  Spanish/Castilian  Swahili/Kiswahili  Tagalog  Tamil  Telugu  Thai  Tigrinya
- Ukrainian  Urdu  Vietnamese  Other language: \_\_\_\_\_  Patient declined to respond  Unknown

Interpreter needed  Yes  No  Unk

**EMPLOYMENT AND SCHOOL**

Employed  Yes  No  Unk Occupation \_\_\_\_\_ Industry \_\_\_\_\_  
 Employer \_\_\_\_\_ Work site \_\_\_\_\_ City \_\_\_\_\_

Student/Day care  Yes  No  Unk  
 Type of school  Preschool/day care  K-12  College  Graduate School  Vocational  Online  Other  
 School name \_\_\_\_\_ School address \_\_\_\_\_  
 City/State/County \_\_\_\_\_ Zip \_\_\_\_\_ Phone number \_\_\_\_\_ Teacher's name \_\_\_\_\_

**COMMUNICATIONS**

Primary HCP name \_\_\_\_\_ Phone \_\_\_\_\_  
 OK to talk to patient (If Later, provide date)  Yes  Later \_\_\_/\_\_\_/\_\_\_  Never  
 Date of interview attempt \_\_\_/\_\_\_/\_\_\_  Complete  Partial  Unable to reach  Patient could not be interviewed  
 Alternate contact:  Parent/Guardian  Spouse/Partner  Friend  Other \_\_\_\_\_  
 Name \_\_\_\_\_ Phone \_\_\_\_\_

Outbreak related  Yes  No LHJ Cluster ID \_\_\_\_\_ Cluster Name \_\_\_\_\_

**CLINICAL INFORMATION**

Complainant ill  Yes  No  Unk  
 Illness duration \_\_\_\_\_  Days  Weeks  Months  Years Illness is still ongoing  Yes  No  Unk  
 Symptoms  Yes  No  Unk Symptom Onset \_\_\_/\_\_\_/\_\_\_  Derived Diagnosis date \_\_\_/\_\_\_/\_\_\_  
 Is this case a pediatric flu death (**case under age 18 years**)  Yes  No  Unk **If yes, complete ALL sections of this form**

**Clinical Features**

**Y N Unk**

Any fever, subjective or measured Temp measured?  Yes  No Highest measured temp \_\_\_\_\_°F  
   Cough Onset date \_\_\_/\_\_\_/\_\_\_  
   Croup  
   Diarrhea (3 or more loose stools within a 24 hour period)  
   Dyspnea (shortness of breath)  
   Fatigue  
   Malaise  
   Headache  
   Myalgia (muscle aches or pain)  
   Nausea  
   Vomiting

**Y N Unk**

Seizure new with disease  
   Pharyngitis (sore throat)  
   Pneumonia Diagnosed by  X-Ray  CT  MRI  Provider Only  
 Result  Positive  Negative  Indeterminate  Not tested  Other \_\_\_\_\_  
   Rash  
   Other symptoms consistent with this illness \_\_\_\_\_  
   Acute respiratory distress syndrome (ARDS)  
   Any other complication \_\_\_\_\_  
 Chest X-ray or CAT scan results  Normal  Detected new abnormality  Not performed  Unk

*Pediatric Death Only*

**Y N Unk**

Bronchiolitis  
   Encephalitis or encephalomyelitis  
   Hemorrhagic pneumonia/pneumonitis  
   Myocarditis  
   Cerebral palsy  
   Reye syndrome  
   Shock  
   Neurologic/neurodevelopmental disorder \_\_\_\_\_  
   Moderate to severe developmental delay  
   Sepsis syndrome  
   Another viral co-infection \_\_\_\_\_  
   Did cardiac/respiratory arrest occur outside the hospital

**Predisposing Conditions**

**Y N Unk**

Alcohol or drug abuse  
   Asthma/reactive airway disease

**Y N Unk**

- Cancer chemotherapy in past 12 months \_\_\_\_\_
- Chronic heart disease \_\_\_\_\_
- Chronic lung disease (e.g., COPD, emphysema) \_\_\_\_\_
- Connective tissue disorder \_\_\_\_\_
- Current tobacco smoker
- Diabetes mellitus
- Hemoglobinopathy (e.g., sickle cell disease)
- HIV positive/AIDS
- Non-cancer immunosuppressive condition \_\_\_\_\_
- Steroid therapy
- Liver disease
- Obesity Height (in inches) \_\_\_\_\_ Weight (in pounds) \_\_\_\_\_
- Organ transplant
- Other underlying medical conditions \_\_\_\_\_
- Frequently use a stroller or wheelchair Describe \_\_\_\_\_

*Pediatric Death Only*

**Y N Unk**

- Cystic fibrosis
- History of febrile seizures
- Cancer diagnosis or treatment in 12 months prior to onset \_\_\_\_\_
- Chromosomal abnormality/genetic syndrome \_\_\_\_\_
- Chronic kidney disease \_\_\_\_\_
- Immunosuppressive therapy before illness onset \_\_\_\_\_
- Neuromuscular disorder (e.g., muscular dystrophy) \_\_\_\_\_
- History of seizures
- Mitochondrial disorder \_\_\_\_\_
- Premature at birth Gestation age \_\_\_\_\_ weeks
- Skin or soft tissue infection (SSTI)
- Endocrine disorder \_\_\_\_\_

**Pregnancy**

Pregnancy status at time of symptom onset

- Pregnant (Estimated) delivery date \_\_\_/\_\_\_/\_\_\_ Weeks pregnant at any symptom onset \_\_\_\_\_  
 OB name, phone, address \_\_\_\_\_  
 Outcome of pregnancy  Still pregnant  Fetal death (miscarriage or stillbirth)  Abortion  
 Other \_\_\_\_\_  
 Delivered – full term  Delivered – preemie  Delivered – Unk  
 Delivery method  Vaginal  C-section  Unk
- Postpartum (Estimated) delivery date \_\_\_/\_\_\_/\_\_\_  
 OB name, phone, address \_\_\_\_\_  
 Outcome of pregnancy  Fetal death (miscarriage or stillbirth)  Abortion  
 Other \_\_\_\_\_  
 Delivered – full term  Delivered – preemie  Delivered – Unk  
 Delivery method  Vaginal  C-section  Unk
- Neither pregnant nor postpartum  Unk

**Vaccination**

**Y N Unk**

- Vaccinated against influenza in the past year
- Vaccine information available  Yes  No
- Date of vaccine administration \_\_\_/\_\_\_/\_\_\_ Vaccine administered (Type) \_\_\_\_\_
- Vaccine lot number \_\_\_\_\_ Administering provider \_\_\_\_\_

*Pediatric Death Only*

**Y N Unk**

- Influenza vaccine in previous season
- Received 2 doses of vaccine during a previous season (if patient was less than 8 years of age at the time of death)

**Clinical testing**

**Y N Unk**

Leukopenia defined as total white blood cell count < 5,000/mm<sup>3</sup>

When was the specimen collected that indicated novel influenza A virus infection by Reverse Transcription-Polymerase Chain Reaction (RT-PCR) \_\_\_/\_\_\_/\_\_\_

Where was the specimen collected  Doctor's office  Hospital  Emergency room  Urgent care clinic  
 Health department  Unk  Other \_\_\_\_\_

**Y N Unk**

Was a rapid influenza diagnostic test (RIDT) used on any respiratory specimens collected

When was the specimen collected \_\_\_/\_\_\_/\_\_\_

Result  Influenza A  Influenza B  Influenza A/B (typed not distinguished)  Negative  Other \_\_\_\_\_

What brand of RIDT test \_\_\_\_\_

Lymphopenia defined as total lymphocytes <800/mm<sup>3</sup> or lymphocytes <15% of WBC

Thrombocytopenia defined as platelets < 150,000 /mm<sup>3</sup>

*Pediatric Death Only*

**Y N Unk**

Pathology specimens sent to CDCs Infectious Disease Pathology Branch Lab ID \_\_\_\_\_

Influenza isolates or original clinical material sent to CDCs Influenza Division Lab ID \_\_\_\_\_

Were other respiratory specimens collected for bacterial culture (e.g., sputum, ET tube aspirate) Specify \_\_\_\_\_

Was a specimen collected for bacterial culture from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid)? *Specimens collected greater than 24 hours after death are not sterile*

Specimen type  Blood  Pleural fluid  Lung tissue  CSF  Unk  Other \_\_\_\_\_

Collection date \_\_\_/\_\_\_/\_\_\_ Result  Positive  Negative  Unk

**Physician Reporting/Patient Healthcare**

When did the patient feel back to normal \_\_\_/\_\_\_/\_\_\_

**Y N Unk**

Did the patient receive any medical care for this illness

Where did the patient seek care  Doctor's office  Urgent care clinic  Emergency department  
 Health department  Unk  Other \_\_\_\_\_

Date seen \_\_\_/\_\_\_/\_\_\_

**Hospitalization**

**Y N Unk**

Hospitalized at least overnight for this illness Facility name \_\_\_\_\_

Hospital admission date \_\_\_/\_\_\_/\_\_\_ Discharge \_\_\_/\_\_\_/\_\_\_ HRN \_\_\_\_\_

Admitted to ICU Date admitted to ICU \_\_\_/\_\_\_/\_\_\_ Date discharged from ICU \_\_\_/\_\_\_/\_\_\_

Mechanical ventilation or intubation required Required for \_\_\_\_\_ days

Still hospitalized As of \_\_\_/\_\_\_/\_\_\_

Where was the patient discharged  Home  Nursing/rehab  Hospice  Unk  Other \_\_\_\_\_

**Y N Unk**

Died of this illness Death date \_\_\_/\_\_\_/\_\_\_ *Please fill in the death date information on the Person Screen*

Autopsy performed

Was a specimen (e.g., fixed lung tissue) collected from an autopsy for testing of bacterial pathogens by a local or state pathologist?

Death certificate lists disease as a cause of death or a significant contributing condition

Health care visit prior to death

Location of death  Outside of hospital (e.g., home or in transit to the hospital)  Emergency department (ED)  
 Inpatient ward  ICU  Other \_\_\_\_\_

**RISK AND RESPONSE (Ask about exposures in the 7 days before symptom onset)**

**Travel**

**Y N Unk**

In the 7 days prior to illness onset, did the patient travel outside of his/her usual area

Did the patient travel in a group  No  With household members  With non-household members  Unk

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name			
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

**Risk and Exposure Information**

**Y N Unk**

- Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country \_\_\_\_\_
- Contact with person with pneumonia or influenza-like illness
- Congregate living
  - Barracks  Corrections  Long term care  Dormitory  Boarding school  Camp  Shelter
  - Other \_\_\_\_\_
- (Potential) Occupational exposure

*In the 7 days before or after symptom onset*

How many people resided in the patient's household(s) \_\_\_\_\_

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

Row	Household (HH) ID	Relation to patient (e.g., parent, brother, friend)	Name	Sex	Age	Fever or any respiratory symptoms +/- 7 days from case patient's onset	Date of illness onset	If HH member ILL		If HH member NOT ILL
								Any pig/hog contact ≤7 days before his/her onset	Attend agricultural fair ≤7 days before his/her onset	Any pig/hog contact or fair attendance ≤10 days before patient's onset
1	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3			<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
2	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3			<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3			<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3			<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3			<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
6	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3			<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

*In the 7 days before or after symptom onset*

**Y N Unk**

- Did the patient attend or work at a childcare facility  
Approximately how many children are in the patient's class or room at the childcare facility \_\_\_\_\_
- Did the patient attend or work at a school  
Approximately how many students are in the patient's class at the school \_\_\_\_\_
- Did anyone else in the patient's household(s) work at or attend a childcare facility or school  
List row number from table above for household members working at or attending a child care facility or school \_\_\_\_\_

*In the 7 days before symptom onset*

**Y N Unk**

- Did the patient attend an agricultural fair/event or live animal market  
Name(s) or fair(s) \_\_\_\_\_  
On what days did the patient attend an agricultural fair/event or live animal market (select all that apply)  
 On day of illness onset  1 day before  2 days before  3 days before  4 days before  5 days before  
 6 days before  7 days before
- Does anyone else in the household own, keep or care for livestock animals  
What type(s) or animals are kept or cared for by household members (check all that apply)  
 Horse  Cows  Poultry/wild birds  Sheep  Goats  Pig/hogs  Other \_\_\_\_\_
- Does the patient handle samples (animal or human) suspected of containing influenza virus in a laboratory or other setting

*In the 7 days before or after symptom onset*

**Y N Unk**

- Did the patient have DIRECT contact with (touch or handle) any livestock animals like poultry or pigs  
 What type(s) of animals did the patient have direct contact with  
 Horse  Cows  Poultry/wild birds  Sheep  Goats  Pig/hogs  Other \_\_\_\_\_  
 Where did the direct contact occur  
 Home  Work  Agricultural fair or event  Live animal market  Petting zoo  Other \_\_\_\_\_
- Did the patient have INDIRECT contact with (walk through an area containing or come within 6 feet of) any livestock animals  
 What type(s) of animals did the patient have indirect contact with  
 Horse  Cows  Poultry/wild birds  Sheep  Goats  Pig/hogs  Other \_\_\_\_\_  
 Where did the indirect contact occur  
 Home  Work  Agricultural fair or event  Live animal market  Petting zoo  Other \_\_\_\_\_

*If ANY contact with animals*

- Did the patient have direct or indirect contact with any animal exhibiting signs of illness  
 Animal type/location \_\_\_\_\_

*If ANY contact with pigs/hogs*

- On what days did the patient have ANY contact (direct, indirect or both) with pigs  
 On day of illness onset  1 day before  2 days before  3 days before  4 days before  5 days before  
 6 days before  7 days before
- What was the total number of different days the patient reported ANY pig contact (direct or indirect, or both)  
 1 day  2 days  3 days  4 days  5 days  6 days  7 days

*In the 7 days before or after symptom onset*

**Y N Unk**

- Did the patient work or volunteer at a healthcare facility or setting  
 Healthcare facility job/role  Physician  Nurse  Administration staff  Housekeeping  Patient transport  
 Volunteer  Other \_\_\_\_\_
- Was the patient in a hospital for any reason (e.g., visiting, working, or for treatment)  
 Earliest exposure date \_\_\_/\_\_\_/\_\_\_ Latest exposure date \_\_\_/\_\_\_/\_\_\_ City/town \_\_\_\_\_
- Was the patient in a clinic or doctor's office for any reason  
 Earliest exposure date \_\_\_/\_\_\_/\_\_\_ Latest exposure date \_\_\_/\_\_\_/\_\_\_ City/town \_\_\_\_\_
- Did the patient have close contact (e.g., caring for, speaking with, or touching) with anyone other than a household member who routinely has contact with pigs/hogs
- 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?

Relation to patient (e.g., parent, brother, friend)	Name	Sex	Age	Date of illness onset	Any pig/hog contact or fair attendance ≤7 days before his/her onset	Comments
		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	

**Y N Unk**

- 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

Relation to patient (e.g., parent, brother, friend)	Name	Sex	Age	Date of illness onset	Any pig/hog contact or fair attendance ≤7 days before his/her onset	Comments
		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	

**Y N Unk**

Is the patient a contact of a confirmed or probable case of novel influenza A infection

Relation to patient (e.g., parent, brother, friend)	Name	State Epi ID	State Lab ID	Case Status	Sex	Age	Date of illness onset
				<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk		
				<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk		
				<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk		
				<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk		
				<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk		
				<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk		

Additional comments/note (e.g., travel details, names/dates or fairs attended by case patient, dates of household member fair attendance and location of fair, information about other ill contacts)

No risk factors or likely exposures could be identified

**Exposure and Transmission Summary**

**Y N Unk**

Epi-link to a confirmed or probable case of novel influenza

Outbreak related

Likely geographic region of exposure  In Washington – county \_\_\_\_\_  Other state \_\_\_\_\_  
 Not in US - country \_\_\_\_\_  Unk

International travel related  During entire exposure period  During part of exposure period  No international travel

Suspected exposure type  Foodborne  Waterborne  Animal related  Vectorborne  Person to person  Sexual  
 Blood products  IDU  Healthcare Associated  Unk  Other \_\_\_\_\_  
 Describe \_\_\_\_\_

Suspected exposure setting  Daycare/Childcare  School (not college)  Doctor's office  Hospital ward  Hospital ER  
 Hospital outpatient facility  Home  Work  College  Military  Correctional facility  Place of worship  
 Laboratory  Long term care facility  Homeless/shelter  International travel  Out of state travel  Transit  
 Social event  Large public gathering  Restaurant  Hotel/motel/hostel  Other \_\_\_\_\_  
 Describe \_\_\_\_\_

Exposure summary \_\_\_\_\_

Suspected transmission type (check all that apply)  Foodborne  Waterborne  Animal related  Vectorborne  
 Person to person  Sexual  Blood products  IDU  Healthcare Associated  Unk  
 Other \_\_\_\_\_  
 Describe \_\_\_\_\_

Suspected transmission setting (check all that apply)  Daycare/Childcare  School (not college)  Doctor's office  
 Hospital ward  Hospital ER  Hospital outpatient facility  Home  Work  College  Military  
 Correctional facility  Place of worship  Laboratory  Long term care facility  Homeless/shelter  
 International Travel  Out of state travel  Transit  Social event  Large public gathering  Restaurant  
 Hotel/motel/hostel  Other \_\_\_\_\_  
 Describe \_\_\_\_\_

**Public Health Interventions/Actions**

**Y N Unk**  
   Facility notified  
   Home isolation instructions given Date given \_\_\_/\_\_\_/\_\_\_  
   Follow-up of appropriate contacts  
 Number recommended for quarantine \_\_\_\_\_  
   Contact quarantine instructions given  
   Letter sent Date \_\_\_/\_\_\_/\_\_\_ Batch date \_\_\_/\_\_\_/\_\_\_

**TRANSMISSION TRACKING**

Visited, attended, employed, or volunteered at any public settings while contagious  Yes  No  Unk  
 Settings and details (check all that apply)  
 Daycare  School  Airport  Hotel/Motel/Hostel  Transit  Healthcare  Home  Work  College  
 Military  Correctional facility  Place of worship  International travel  Out of state travel  LTCF  
 Homeless/shelter  Social event  Large public gathering  Restaurant  Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

*If list of contacts is known, please fill out Contact Tracing Form Question Package*



**TREATMENT****Y N Unk**

Did patient receive influenza antiviral medication prior to becoming ill (within 2 weeks) or after becoming ill  
*If Yes, please list any antiviral medications in the prophylaxis/treatment section below*

Did patient receive prophylaxis/treatment

Specify medication \_\_\_\_\_  Antiviral  Other \_\_\_\_\_

Number of days actually taken \_\_\_\_\_ Treatment start date \_\_\_/\_\_\_/\_\_\_ Treatment end date \_\_\_/\_\_\_/\_\_\_

Prescribed dose \_\_\_\_\_  g  mg  ml Frequency \_\_\_\_\_ Duration \_\_\_\_\_  Days  Weeks  Months

Indication  PEP  Treatment for disease  Incidental  Other \_\_\_\_\_

Did patient take medication as prescribed  Yes  No - Why not \_\_\_\_\_  Unk

Prescribing provider \_\_\_\_\_

**NOTES****LAB RESULTS**

Lab report information

**Lab report reviewed – LHJ**

WDRS user-entered lab report note

Submitter \_\_\_\_\_

Performing lab for entire report \_\_\_\_\_

Referring lab \_\_\_\_\_

Specimen

**Specimen identifier/accession number** \_\_\_\_\_

**Specimen collection date** \_\_\_/\_\_\_/\_\_\_ **Specimen received date** \_\_\_/\_\_\_/\_\_\_

**WDRS specimen type** \_\_\_\_\_

WDRS specimen source site \_\_\_\_\_

WDRS specimen reject reason \_\_\_\_\_

Test performed and result

**WDRS test performed** \_\_\_\_\_

**WDRS test result, coded** \_\_\_\_\_

WDRS test result, comparator \_\_\_\_\_

**WDRS result, numeric only** (enter only if given, including as necessary **Comparator** and **Unit of measure**) \_\_\_\_\_

WDRS unit of measure \_\_\_\_\_

Test method \_\_\_\_\_

WDRS interpretation code \_\_\_\_\_

Test result – Other, specify \_\_\_\_\_

**WDRS result summary**  Positive  Negative  Indeterminate  Equivocal  Test not performed  Pending

Test result status  Final results; Can only be changed with a corrected result

Preliminary results

Record coming over is a correction and thus replaces a final result

Results cannot be obtained for this observation

Specimen in lab; results pending

Result date \_\_\_/\_\_\_/\_\_\_

**Upload document**

Ordering Provider

WDRS ordering provider \_\_\_\_\_

Ordering facility

WDRS ordering facility name \_\_\_\_\_

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email [doh.information@doh.wa.gov](mailto:doh.information@doh.wa.gov).