

Initial Swine Influenza Case Report Form



ACDC ID: _____ VCMR ID: _____

Clinicians should consider swine influenza infection in the differential diagnosis of patients with:

- Influenza-like illness (ILI) defined as fever $\geq 37.8^{\circ}\text{C}$ (100°F) and a cough and/or sore throat

AND at least one of the following (check all the apply):

- Are a contact to a confirmed swine influenza A (H1N1) case
- Are part of a cluster of people reported with ILI
- Traveled to affected areas including Mexico [check www.cdc.gov/swineflu/investigation.htm for affected states/countries and www.cdph.ca.gov/healthinfo/discond/pages/swineinfluenza.aspx for specific affected California counties] in the 7 days preceding illness onset
- Were in contact with persons with ILI who were in affected areas during the 7 days preceding illness onset
- Are hospitalized with ILI or pneumonia

Tests will not be performed on isolates of cases that do not meet above case definition.

Patient Name-Last	First	Middle Initial	Date of birth	Age	Sex
Address- Number, Street, Apt #		City	State	ZIP Code	
Home phone ()		Work phone ()		Cell phone ()	
Race (check one) <input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Other: _____			Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino		
Occupation		Student? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Specify school. _____			

PRESENT ILLNESS

Onset date	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Admit date	Discharge date	Medical record no.	Hospital Name		
Level of medical care (check all that apply): <input type="checkbox"/> Outpatient clinic <input type="checkbox"/> Emergency Room <input type="checkbox"/> Inpatient ward <input type="checkbox"/> Intensive Care Unit <input type="checkbox"/> None				Significant past medical history: No underlying medical conditions <input type="checkbox"/>			
Symptoms that occurred during current illness (check all that apply): <input type="checkbox"/> Fever ($\geq 37.8^{\circ}\text{C}$ / 100°F) <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Sore throat <input type="checkbox"/> Cough <input type="checkbox"/> Nausea/Vomiting/Diarrhea <input type="checkbox"/> Muscle ache <input type="checkbox"/> Other Specify: _____				Yes	No	Unk	
				Cardiac disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complications that occurred during acute illness(check all that apply): <input type="checkbox"/> Pneumonia/ARDS <input type="checkbox"/> Secondary bacterial pneumonia <input type="checkbox"/> Bronchiolitis <input type="checkbox"/> Encephalitis/encephalopathy <input type="checkbox"/> Myocarditis <input type="checkbox"/> Sepsis/Multi-Organ Failure <input type="checkbox"/> Other Specify: _____				Chronic pulmonary disorder (e.g. asthma, cystic fibrosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Immunosuppression (e.g. HIV, malignancy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Died? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date of death: _____				Metabolic disorder (e.g. diabetes mellitus, renal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Developmental delay.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes for any of the above, please specify in Remarks section.				Long-term aspirin therapy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Steroids by mouth/injection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____				Cancer chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Radiation therapy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Pregnancy.....If Yes, specify # of weeks ____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Other conditions.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient name (last, first) _____ Date of Birth _____ VCMR ID: _____

DIAGNOSTIC TESTS

Laboratory studies:

Chest X-ray: Positive Negative Not done Findings: _____

Other pertinent labs (LFTs, MRI/CT, etc.), if available. _____

Previous Influenza/Microbiology testing:

Type of microbiology test (check all that apply)	Collection date	Influenza result
<input type="checkbox"/> PCR		<input type="checkbox"/> Influenza A non-typable <input type="checkbox"/> Influenza A typable <input type="checkbox"/> Influenza B <input type="checkbox"/> Neg
<input type="checkbox"/> Viral Culture		<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative
<input type="checkbox"/> Rapid Influenza Test (EIA)		<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Influenza A/B <input type="checkbox"/> Neg
<input type="checkbox"/> IFA/DFA		<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Neg
<input type="checkbox"/> Other: Specify: _____		

Other viral/bacterial pathogens detected? : Yes* No Unk

If yes*, specify source: Sputum ET asp BAL Pleural Fluid Blood Other, specify: _____

If yes*, specify pathogen: _____

Blood culture: Positive* Negative Not done

If Positive*, pathogen: _____

Respiratory culture: Positive* Negative Not done

If Positive*, specify specimen (n-p swab/wash, o-p swab, ET aspirate, sputum, BAL, pleural fluid) and pathogen: _____

Other micro results: _____

REMARKS

CONTACT INFORMATION Date of Report: _____

Physician/Infection Preventionist Name	Facility	Pager/Phone number ()	E-mail address
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To report a case, fax this form to: Los Angeles County Department of Public Health
Acute Communicable Disease Control Phone 213-240-7941 Fax 213-482-4856