

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

- Date of birth: ____ / ____ / ____ (MM/DD/YYYY)
- Country of usual residence: _____
- Primary language spoken: _____
- Race: (check all that apply) White Asian American Indian/Alaska Native Black
 Native Hawaiian/Other Pacific Islander
- Ethnicity: Hispanic or Latino Not Hispanic or Latino
- 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
- 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
- Occupation: _____ If farmworker, list specific job duties (e.g., milks cows): _____

Symptoms, Clinical Course, Treatment, Testing, and Outcome

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

Symptom	Symptom Present?	Symptom	Symptom Present?
Fever (highest temp _____ °F)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
If fever present, date of onset	/ / (MM/DD/YYYY)	Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Felt feverish	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
If felt feverish, date of onset	/ / (MM/DD/YYYY)	Eye infection/redness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Muscle aches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other, specify	

- Did the patient receive any medical care for the illness?
 Yes No Unknown
- 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
- 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) mg
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	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
2	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
3	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
4	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
5	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
6	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 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)
			<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable			
			<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable			
			<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable			
			<input type="checkbox"/> Confirmed <input type="checkbox"/> 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/mm³) associated with this illness?

Yes No Test not performed Unknown

74. Did the patient have lymphopenia (total lymphocytes <800/mm³ 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/mm³) 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
