Washington State Department of HEALTH

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 _____ LHJ Case ID (optional) _____

LHJ 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 _____ LHJ _____

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 childs) 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

Case Name _____ LHJ Case ID _____

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 _____ºF
☐ ☐ ☐ 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/mm3*

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^3 or lymphocytes <15% of WBC*

☐ ☐ ☐ Thrombocytopenia *defined as platelets < 150,000 /mm^3*

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 are 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 ☐ Ukn

	Setting 1	Setting 2	Setting 3
Travel out of:	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ 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	☐ 1 ☐ 2 ☐ 3			☐ M ☐ F ☐ Unk		☐ Y ☐ N ☐ Unk		☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
2	☐ 1 ☐ 2 ☐ 3			☐ M ☐ F ☐ Unk		☐ Y ☐ N ☐ Unk		☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
3	☐ 1 ☐ 2 ☐ 3			☐ M ☐ F ☐ Unk		☐ Y ☐ N ☐ Unk		☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
4	☐ 1 ☐ 2 ☐ 3			☐ M ☐ F ☐ Unk		☐ Y ☐ N ☐ Unk		☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
5	☐ 1 ☐ 2 ☐ 3			☐ M ☐ F ☐ Unk		☐ Y ☐ N ☐ Unk		☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
6	☐ 1 ☐ 2 ☐ 3			☐ M ☐ F ☐ Unk		☐ Y ☐ N ☐ Unk		☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ 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
		☐ M ☐ F ☐ Unk			☐ Y ☐ N ☐ Unk	
		☐ M ☐ F ☐ Unk			☐ Y ☐ N ☐ Unk	
		☐ M ☐ F ☐ Unk			☐ Y ☐ N ☐ Unk	
		☐ M ☐ F ☐ Unk			☐ Y ☐ N ☐ Unk	
		☐ M ☐ F ☐ Unk			☐ Y ☐ N ☐ Unk	
		☐ M ☐ F ☐ Unk			☐ Y ☐ N ☐ 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

Case Name _____ LHJ Case ID _____

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
		☐ M ☐ F ☐ Unk			☐ Y ☐ N ☐ Unk	
		☐ M ☐ F ☐ Unk			☐ Y ☐ N ☐ Unk	
		☐ M ☐ F ☐ Unk			☐ Y ☐ N ☐ Unk	
		☐ M ☐ F ☐ Unk			☐ Y ☐ N ☐ Unk	
		☐ M ☐ F ☐ Unk			☐ Y ☐ N ☐ Unk	
		☐ M ☐ F ☐ Unk			☐ Y ☐ N ☐ 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
				☐ Confirmed ☐ Probable	☐ M ☐ F ☐ Unk		
				☐ Confirmed ☐ Probable	☐ M ☐ F ☐ Unk		
				☐ Confirmed ☐ Probable	☐ M ☐ F ☐ Unk		
				☐ Confirmed ☐ Probable	☐ M ☐ F ☐ Unk		
				☐ Confirmed ☐ Probable	☐ M ☐ F ☐ Unk		
				☐ Confirmed ☐ Probable	☐ M ☐ F ☐ 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 _____

Case Name _____ LHJ Case ID _____

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)	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
Is a list of contacts known?	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk

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

Case Name _____ LHJ Case ID _____

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 _____