Washington State Department of Health

For influenza deaths, complete page 1 and healthcare worker question on page 2.

LHJ Use **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed**

By: ☐ **Lab** ☐ **Clinical**
☐ Epi Link: _____

☐ **Outbreak-related**
LHJ Cluster# _____
LHJ Cluster Name: _____
PHL Lab # _____
DOH Outbreak # _____

Influenza

County

REPORT SOURCE

LHJ notification date ___/___/___ Investigation start date ___/___/___
Reporter (check all that apply) ☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other

OK to talk to case? ☐Yes ☐No ☐DK Date of interview ___/___/___

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Zip code (school or occupation): _____ Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino ☐ Unk
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other ☐ Unk
Language:_____

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms (complete symptoms for novel flu only)

Y	N	DK	NA	
☐	☐	☐	☐	Fever Highest measured temp (°F): ____
☐	☐	☐	☐	Cough Onset date ___/___/___
☐	☐	☐	☐	Sore throat
☐	☐	☐	☐	Shortness of breath
☐	☐	☐	☐	Vomiting
☐	☐	☐	☐	Diarrhea

Predisposing Conditions

Y	N	DK	NA	
☐	☐	☐	☐	Any current conditions such as:

☐ Smoker ☐ Alcohol or drug use
☐ Chemotherapy ☐ Neuromuscular disease
☐ Steroid therapy ☐ Organ transplant
☐ HIV/AIDS ☐ Chronic liver disease
☐ Cancer past yr. ☐ Chronic heart disease
☐ Asthma ☐ Chronic lung disease
☐ Diabetes ☐ Chronic kidney disease
☐ Cognitive abnl. ☐ Hemoglobinopathy
☐ Obesity Ht:___(in) Wt:____(lbs)
☐ Other: _____

☐ ☐ ☐ ☐ Pregnant if yes, weeks: _____
outcome: _____

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	Pneumonia on x-ray, CT, or MRI
☐	☐	☐	☐	Acute respiratory distress syndrome (ARDS)
☐	☐	☐	☐	Admitted to intensive care unit
☐	☐	☐	☐	Mechanical ventilation
☐	☐	☐	☐	Treated with antiviral medications

Type 1, dose: _____
Dates started:___/___/___ stopped:___/___/___
Type 2, dose:_____
Dates started:___/___/___ stopped:___/___/___

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized at least overnight for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	**Died from illness** Death date ___/___/___
☐	☐	☐	☐	Healthcare visit prior to death
☐	☐	☐	☐	Autopsy ☐ Specimens available: _____

Vaccination

Y	N	DK	NA	
☐	☐	☐	☐	Seasonal influenza vaccine this flu season Doses: __

Date(s) and type(s) e.g., shot, spray: _____

Laboratory

P = Positive O = Other N = Negative
NT = Not Tested I = Indeterminate

P	N	I	O	NT	
☐	☐	☐	☐	☐	**Influenza rapid test or EIA** Test type:_____
					Date: ___/___/___ Specimen type: _____
☐	☐	☐	☐	☐	**Influenza PCR** Test type:_____ Lab:_____
					Date: ___/___/___ Specimen type: _____
☐	☐	☐	☐	☐	**Influenza culture** Test type:_____
					Date: ___/___/___ Specimen type: _____
☐	☐	☐	☐	☐	**DFA or IFA for influenza** Test type:_____
					Date: ___/___/___ Specimen type: _____
☐	☐	☐	☐	☐	Bacterial cultures
					Date: ___/___/___ Specimen type: _____
					Result:☐MRSA ☐MSSA ☐Strep☐Haemophilus
					Other:_____

Influenza test results:
LHJ Species/Organism ☐ A ☐ B ☐ Unk ☐ Other
LHJ Serotype/Serogroup
☐ A 2009 H1N1 ☐ A H1
☐ A H3 ☐ A H1N1 (other)
☐ A H3N2 ☐ A H5, avian
☐ Unknown ☐ A, unknown, but not 2009 H1N1
☐ Other ☐ Pending

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

	Exposure period*	onset	***Contagious period***
Days from onset:	-7 -1		Contagious one day before symptoms to 24 hours after last symptom; longer in children.
Calendar dates:			

EXPOSURE (only required for novel flu infections)

Y N DK NA

☐ ☐ ☐ ☐ Travel to an area with confirmed novel flu

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Dates/Locations: _____
_____
_____

☐ ☐ ☐ ☐ Number people in household including case: ____

☐ ☐ ☐ ☐ Contact with pneumonia or influenza-like illness

☐ ☐ ☐ ☐ Health care worker

Y N DK NA

☐ ☐ ☐ ☐ Health care setting exposure
☐ Lab ☐ Health care worker ☐ Patient
Setting: ☐ Hospital ☐ ER ☐Outpatient
☐ Long term care ☐ Other _____

☐ ☐ ☐ ☐ Congregate living or employment
☐ Barracks ☐ Corrections ☐ Long term care
☐ Dormitory ☐ Boarding school ☐ Camp
☐ Shelter ☐ Other: _____

☐ ☐ ☐ ☐ Poultry or farm animal exposure
Type: ☐ Poultry (chicken, duck, goose)
☐ Wild bird ☐ Swine, pig ☐ Other: _____
Animals were ☐ Healthy ☐ Sick ☐ Unk
Description and location of contact (e.g., farm):
_____

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

Exposure details: _____

PUBLIC HEALTH ISSUES (only required for novel flu)

Y N DK NA

☐ ☐ ☐ ☐ Nosocomial infection suspected

☐ ☐ ☐ ☐ Work or volunteer in health care setting during contagious period
Facility name: _____

☐ ☐ ☐ ☐ Close contact works in health care setting

PUBLIC HEALTH ACTIONS (only required for novel flu)

☐ Outbreak investigation

☐ Home isolation instructions given Date: ____/____/_____

☐ Contact quarantine instructions given
Number recommended for quarantine: _____

☐ Facility notified

NOTES

OPTIONAL TRAVEL WORKSHEET

Dates	Departure/arrival cities	Mode of travel (air, bus, etc.)	Number (e.g., flight)	Ill contacts

OPTIONAL HOUSEHOLD WORKSHEET

# Name	Relationship*	Age (yrs)	Ill (Y/N)	T>100F	Cough	Sore throat	Diarrhea	Onset
1								**/ /**
2								**/ /**
3								**/ /**
4								**/ /**
5								**/ /**

***** 1=spouse, 2=mother, 3=father, 4=child, 5=sister, 6=brother, 7=cousin, 8=aunt, 9=uncle, 10=grandmother, 11=grandfather, 12=no relation, 19=other

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____ **Record complete date** ___/___/___

Influenza: case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered