

CALIFORNIA DEPARTMENT OF HEALTH SERVICES SCREENING FORM FOR SUSPECT AVIAN (H5N1) INFLUENZA



Patient's Last Name: _____ First Name: _____

Address: _____ City: _____ County: _____

Date of Birth ___/___/___ or Age: _____ Race: _____ Gender: Male Female Phone: _____

Occupation (if HCW, note type and if direct patient care involved): _____

CASE DEFINITION CRITERIA FOR SUSPECT H5N1 (ALL 3 CRITERIA MUST BE MET):

NOTE: Refer to http://www.oie.int/download/AVIAN%20INFLUENZA/A_AI-Asia.htm (click on "GRAPH" at the top of page) for an updated list of affected countries.

1. Within 10 days of symptom onset, did the patient travel to an area with documented avian (H5N1) influenza in poultry and/or humans?
 Yes No Unk If yes, list country (ies) and dates of travel: _____
2. Is the patient either:
 - a. Hospitalized with radiographically-confirmed pneumonia, ARDS or a respiratory illness for which an alternate diagnosis is not established?
 Yes No Unk **OR**
 - b. Hospitalized **or** outpatient with documented fever >38°C **AND** either cough, sore throat, or shortness of breath? Yes No Unk
3. Within 10 days of symptom onset, did the patient have any of the following exposures in an H5N1-affected country?
 - a. Direct contact with domestic poultry* (e.g. touching sick or dead chickens or ducks or well-appearing ducks?) Yes No Unk
 - b. Consumption of uncooked poultry* or poultry* products? Yes No Unk
 - c. Direct contact with surfaces contaminated with poultry* feces? Yes No Unk
 - d. Close contact (within 1 meter) with a known or suspected human case of H5N1? Yes No Unk

Comments: _____

*The definition of poultry is: domestic fowls, such as chickens, turkeys, ducks, or geese, raised for meat or eggs.

CLINICAL INFORMATION/HOSPITAL COURSE

Date of symptom onset: ___/___/___ Date of first clinical evaluation: ___/___/___

Is patient hospitalized? Yes No Unk If yes: Name of hospital and county: _____

Date of admission: ___/___/___ Date of discharge: ___/___/___

Is patient in the ICU? Yes No Unk Intubated? Yes No Unk

Symptoms: (e.g., fever, chills, myalgias, headache, cough, sore throat, n/v, alt mental status, seizures, etc) Documented temp: _____ O₂ sat: _____

Notes on hospital course, complications (e.g., ARDS, bacterial pneumonia, encephalitis, sepsis/MOF, etc) and antibiotics/antivirals received: _____

Past Medical History (also note risk factors for influenza complications, e.g. cardiopulmonary disease, immunosuppression, pregnancy, etc) : _____

Laboratory: WBC with diff: _____ Hct: _____ Platelet: _____ Liver function: AST: _____ ALT: _____

Chest X-ray/CT: _____ Date: ___/___/___

Did the patient die? Yes No Unk If yes, date of death: ___/___/___ Was autopsy performed? Yes No Unk

MICROBIOLOGY RESULTS FROM CLINIC/HOSPITAL/LPHL (e.g., rapid antigen testing, bacterial/viral culture, PCR, biopsy/path results):

Reporting LHD/physician contact: _____ Phone/fax: _____

**Please report any suspect or laboratory-confirmed cases to the County of San Diego's Community Epidemiology Branch
Call 619-515-6620 (M-F 8AM-5PM) or after hours at Station M 858-565-5255
FAX THIS FORM TO 619-515-6644**