# Novel and Pandemic Influenza Case Investigation Form

**Case Information**

Date of Report: _______/_______/_______(DD/MM/YYYY)

State/Local Case Identification Number: _____________________

CDC Case Identification Number: __________________________

Name of case-patient: Last ________________________ First_______________ Initials of case-patient (if not US case):_____________

Postal address: Street__________________________ Village/Town/City _________________________County/District_________________

State/Province____________ _______Zip Code/Postal Code_______________________

GIS coordinates of residence (Latitude Degrees/Minutes/Seconds X Longitude Degrees/Minutes/Seconds) _____________________________

Telephone #_____________________ Cell/Mobile _____________________ Fax _____________________ E-mail ___________________

Immigration status: ☐ US resident ☐ Resides abroad but visiting US

**Reporter Information**

Name of reporter: Last_____________________ First_____________________

Postal address: Street__________________________ City __________________ State/Province____________ Zip Code/Postal Code________

Telephone #_____________________ Cell/Mobile _____________________ Fax _____________________ E-mail ___________________

Reporter's Organization:

State or County Health Department: _____________________ City_____________________ State/Province______________

**Source of Information**

☐ Case-patient

☐ Proxy; IF YES, relationship of proxy to case-patient_____________________ Reason for use of proxy_________________________________

Name of proxy: Last_____________________ First______________________

Postal address: Street__________________________ Village/Town/City _________________________County/District_________________

State/Province____________ _______Zip Code/Postal Code_______________________

Telephone #_____________________ Cell/Mobile _____________________ Fax _____________________ E-mail ___________________

**Case-Patient Demographic Information**

Date of Birth: _______/_______/_______(DD/MM/YYYY)

Race: ☐White ☐ Asian ☐ American Indian/Alaska Native

☐ Black ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Sex: ☐ Male ☐ Female

**Social History and Contact Tracing**

Number of household members (including case patient) _____________________

Does the case-patient have family members or close contacts with pneumonia or severe influenza-like-illness?

[close-contact defined as contact within 1 meter (or 3 feet) with a person (e.g. caring for, speaking with, or touching)]

☐ Yes (complete contact form) ☐ No ☐ N/A ☐ Unknown

[If YES, list any identified contacts on the contact tracing form]

What is the current job of the case-patient? (check all that apply)

☐ Laboratory worker ☐ Health care worker ☐ Poultry farm-worker ☐ Wildlife worker

☐ Veterinary worker ☐ Other animal farm-worker

☐ Other________________ ☐ Other animal husbandry _________________________

How long has the case-patient worked in their current job? (number) _______________ ☐ months ☐ years

If less than six months, list the type of job previously held: (specify job) ____________ (specify length of time at previous job) _________

Does the case-patient work in a health care facility or setting?

☐ Yes (specify name)___________________________ ☐ No ☐ Unknown

**Exposures- *Travel history***

In the 10 days prior to illness onset, did the case-patient travel?

☐ Yes ☐ No ☐ Unknown

If YES, please fill in the arrival and departure dates for all countries visited.

a. Country____________ Arrival__________ Departure__________
Mode of Transportation______________ Flight/Ship #______________

b. Country____________ Arrival__________ Departure__________
Mode of Transportation______________ Flight/Ship #______________

c. Country____________ Arrival__________ Departure__________
Mode of Transportation______________ Flight/Ship #______________

d. Country____________ Arrival__________ Departure__________
Mode of Transportation______________ Flight/Ship #______________

e. Country____________ Arrival__________ Departure__________
Mode of Transportation______________ Flight/Ship #______________

f. Country____________ Arrival__________ Departure__________
Mode of Transportation______________ Flight/Ship #______________

g. Country____________ Arrival__________ Departure__________
Mode of Transportation______________ Flight/Ship #______________

**Exposures-*Contact with probable or confirmed case-patients***

In the 10 days prior to illness onset:

Did the case-patient have close contact (within 1 meter (or 3 feet)) with a person (e.g. caring for, speaking with, or touching) with fever and cough, or pneumonia, or that died of a respiratory illness in the 10 days prior to illness onset?

☐ Yes ☐ No ☐ Unknown

If YES, was the contact in the U.S.A. or international?

☐ US ☐ International ☐ Unknown

If International, in which country or countries?

County: _________________ Date(s) of Contact: ________________________________________________________

County: _________________ Date(s) of Contact: ________________________________________________________

In the 10 days prior to illness onset:

Did the case-patient have close contact (within 1 meter (3 feet)) with a person (e.g. caring for, speaking with, or touching) who is a suspected, probable or confirmed novel (including avian and pandemic) human influenza A case within the week prior to illness onset?

☐ YES ☐ No ☐ Unknown

If YES:

a. Did the patient directly touch or provide physical care for the probable or confirmed case?

☐ YES ☐ No ☐ Unknown

b. Did the patient speak to or touch or any items belonging to the probable or confirmed case?

☐ YES ☐ No ☐ Unknown

In the 10 days prior to illness onset:

Did the case-patient visit or stay in the same household with anyone who died during or following the visit?

☐ Yes ☐ No ☐ Unknown

If this case-patient has a diagnosis of novel influenza A virus infection that has not been laboratory confirmed, is there an epidemiologic link between this patient and a laboratory-confirmed or probable novel influenza A case?

☐ Yes ☐ No ☐ Unknown

In the 10 days prior to illness onset:

Did the case-patient seek care for an unrelated health condition in a healthcare facility known to be simultaneously caring for other suspected or confirmed human cases of avian or novel influenza?

☐ Yes ☐ No ☐ Unknown

**Exposures-*Contact with Poultry and Other Animals***

Are any sick or dead animal(s) present in the case-patient's home, village, neighborhood, or workplace?

☐ Yes ☐ No ☐ Unknown

If YES, which of following are present? (check all that apply)

☐ Chickens/poultry ☐ Wild birds ☐ Pigs ☐ Other (specify)________________________

If YES, what is the status of the animals during the two weeks prior to case-patient illness onset?

☐ Well-appearing ☐ Diseased ☐ Dead (approximate date of death) __________________

If there are sick poultry, are they vaccinated against influenza?

☐ Yes ☐ No ☐ Unknown

If there are sick pigs, are they vaccinated against influenza?

☐ YES ☐ No ☐ Unknown

In the 10 days prior to illness onset, did the case-patient have contact with any of the following animals? (check all that apply)

☐ Chickens/poultry ☐ Wild birds ☐ Pigs ☐ Other (specify)__________________________________

If the patient had contact with animals, please answer the following questions, otherwise skip to the Medical History section:

What was the nature of the contact (check all that apply)?

☐ Direct touching (specify animal(s)) ____________

☐ Proximity within 1 meter but not touching (specify animal(s))______________

If the case-patient directly touched the bird(s) or other animal(s), which of the following did the patient do with the animal: (check all that apply)

☐ Carry/handle ☐ Slaughter/butcher ☐ Prepare for consumption ☐ Other (specify) _________________

If the case-patient directly touched the bird(s) or other animal(s), approximately how many sick or dead birds/animals did the patient touch?

☐ One only ☐ 2-5 ☐ 6-20 ☐ 21-100 ☐ >100

What species of bird(s) or other animal(s) did the case-patient come in contact with? (directly or within 1 meter)

Species #1_________________ Species #2_________________ Species #3_________________

What was the status of the bird(s) or other animal(s) during the two weeks PRIOR to case-patient illness onset?

☐ Well-appearing ☐ Diseased ☐ Dead (approximate date of death) ____________________________

What is the status of the bird(s) or other animal(s) AFTER the onset of illness in the case-patient?

☐ Well-appearing ☐ Diseased ☐ Dead (approximate date of death) ____________________________

Where did the contact occur? (check all that apply)

☐ Live animal market ☐ Commercial animal farm ☐ Backyard animals ☐ Inside home
☐ Cockfighting ☐ Slaughterhouse ☐ Veterinary contact ☐ Hunting
☐ Wildlife ☐ Other contact___________________________

Are the bird(s) or other animal(s) that the case-patient came in contact with vaccinated with any of following influenza vaccines?

☐ H1 ☐ H3 ☐ H5 ☐ Not vaccinated ☐ Unknown vaccination status

Was the contact in the US or international?

☐ US ☐ International ☐ Unknown

If contact was in the US, in which city and state did it occur?

City: ______________ State: ________________ Date: ______________

City: ______________ State: ________________ Date: ______________

If contact was international, in which country or countries did it occur?

City_______________ Province______________ Country: _________________ Dates: __________________

City_______________ Province______________ Country: _________________ Dates: __________________

**Answer the remaining questions in this section in terms of the 10 days prior to the onset of the patient's illness:**

Did the case-patient touch (handle, slaughter, butcher, prepare for consumption) animals (including poultry, wild birds, or swine) or their remains in an area where influenza infection in animals or novel influenza in humans has been suspected or confirmed in the last month?

☐ Yes ☐ No ☐ Unknown

Was the case-patient exposed to animal (including poultry, wild birds, or swine) remains in an area where influenza infection in animals or novel influenza in humans has been suspected or confirmed in the last month?

☐ Yes ☐ No ☐ Unknown

Was the case-patient exposed to environments contaminated by to animal feces (including poultry, wild birds, or swine) in an area where influenza infection in animals or novel influenza in humans has been suspected or confirmed in the last month?

☐ Yes ☐ No ☐ Unknown

Did the case-patient consume raw or undercooked animals (including poultry, wild birds, or swine products) in an area where influenza infections in animals or novel influenza in humans has been suspected or confirmed in the last month?

☐ Yes ☐ No ☐ Unknown

Did the case-patient handle samples (animal or human) suspected of containing influenza virus in a laboratory or other setting?

☐ Yes ☐ No ☐ Unknown

**Medical History-*Vaccination Status***

Was the case-patient vaccinated against human influenza in the past year?

☐ Yes ☐ No ☐ Unknown

If YES, date of vaccination ____/____/____

Type of vaccine: ☐ Inactivated ☐ Live Attenuated ☐ Unknown

Was the case-patient vaccinated against avian influenza A (H5N1)?

☐ Yes ☐ No ☐ Unknown

If YES, date of vaccination: ____/____/____

Type of vaccine: _________________

**Medical History-*Past Medical History***

Is the case-patient pregnant?

☐ Yes (weeks pregnant)____________ ☐ No ☐ Unknown

Does the case-patient have any of the following?

a. Asthma ☐ yes ☐ no ☐ unknown

b. Other chronic lung disease ☐ yes ☐ no ☐ unknown (If YES, specify) _______________________

c. Chronic heart or circulatory disease ☐ yes ☐ no ☐ unknown (If YES, specify) _______________________

d. Metabolic disease (including diabetes mellitus) ☐ yes ☐ no ☐ unknown (If YES, specify) _______________________

e. Kidney disease ☐ yes ☐ no ☐ unknown (If YES, specify) _______________________

f. Cancer in the last 12 months ☐ yes ☐ no ☐unknown (If YES, specify) _______________________

g. Immunosuppressive condition (such as HIV infection, cancer, chronic corticosteroid therapy, diabetes, or organ transplant recipient)

☐ yes ☐ no ☐ unknown (If YES, specify) _______________________

h. Other chronic diseases ☐ yes ☐no ☐ unknown (If YES, specify) _______________________

Is the case-patient on chronic drug therapy?

☐ Yes ☐ No ☐ Unknown

If yes, complete table below

| Drug | Dose | Frequency | Date Initiated |
|---|---|---|---|
| | mg | | |
| | mg | | |
| | mg | | |
| | mg | | |
| | mg | | |

Has the case-patient smoked at least 100 cigarettes in their life? (100 cigarettes = approximately 5 packs) ☐ yes ☐no ☐ unknown

If YES, does the patient now smoke cigarettes: ☐ everyday ☐some days ☐ not at all

**Medical History-*Illness onset and presenting symptoms***

Date of illness onset _________________ (DD/MM/YYYY)

Date(s) of outpatient medical presentation(s) (clinic location, name):

Clinic #1 name: __________________ Date(s): _________________ (DD/MM/YYYY) Telephone #: _____________ Fax #: __________________

Address: ___________________________________________________________________________

Clinic #2 name: __________________ Date(s): _________________ (DD/MM/YYYY) Telephone #: _____________ Fax #: __________________

Address: ___________________________________________________________________________

Date(s) of hospital admission(s):

Hospital #1 Name: ________________________ Telephone#______________________ Fax #: ____________________

Address: ___________________________________________________________________________________

Admission date: __________________ (DD/MM/YYYY)

☐ Discharged (specify date) ______________________ ☐ Transferred (specify date) ___________

Hospital #2 Name: ________________________ Telephone#______________________ Fax #: ____________________

Address: ___________________________________________________________________________________

Admission date: __________________ (DD/MM/YYYY)

☐ Discharged (specify date) ______________________ ☐ Transferred (specify date) ___________

Within the last 7 days, has the case-patient experienced any of the following medical conditions:

| | | | | |
|---|---|---|---|---|
| a. | Coughing | ☐ YES | ☐ NO | ☐ Unknown |
| b. | Diarrhea | ☐ YES | ☐ NO | ☐ Unknown |
| c. | Difficulty breathing (or shortness of breath) | ☐ YES | ☐ NO | ☐ Unknown |
| d. | Eye infection | ☐ YES | ☐ NO | ☐ Unknown |
| e. | Fever (_____°) temp if known | ☐ YES | ☐ NO | ☐ Unknown |
| f. | Feverishness | ☐ YES | ☐ NO | ☐ Unknown |
| g. | Headache | ☐ YES | ☐ NO | ☐ Unknown |
| h. | Muscle aches | ☐ YES | ☐ NO | ☐ Unknown |
| i. | Rash | ☐ YES | ☐ NO | ☐ Unknown |
| j. | Runny nose | ☐ YES | ☐ NO | ☐ Unknown |
| k. | Seizures | ☐ YES | ☐ NO | ☐ Unknown |
| l. | Sore throat | ☐ YES | ☐ NO | ☐ Unknown |
| m. | Vomiting | ☐ YES | ☐ NO | ☐ Unknown |
| n. | Other symptom(s) | ☐ YES | ☐ NO | (specify)________________________ |

**Medical History-*Treatment, Clinical Course, and Outcome***

Did the case-patient receive antiviral medications?

☐ Yes ☐ No ☐ Unknown

If yes, complete table below

| Drug | Dose # 1 | Dose #1 Date Initiated (DD/MM/YYYY) | Dose #1 Date Discontinued (DD/MM/YYYY) | Dose #2 | Dose #2 Date Initiated (DD/MM/YYYY) | Dose #2 Date Discontinued (DD/MM/YYYY) |
|---|---|---|---|---|---|---|
| Oseltamivir | mg | | | mg | | |
| Zanamivir | mg | | | mg | | |
| Rimantadine | mg | | | mg | | |
| Amantadine | mg | | | mg | | |
| Other ____________ | | | | | | |

Did the case-patient receive antibacterial medications?

☐ Yes ☐ No ☐ Unknown

If yes, complete table below

| Drug | Date Initiated | Date Discontinued | Dosage (if known) |
|---|---|---|---|
| | | | mg |
| | | | mg |

| | | | |
|---|---|---|---|
| | | | mg |
| | | | mg |

Did the case-patient receive steroids?

□ Yes □ No □ Unknown

If yes, complete table below

| Drug | Date Initiated | Date Discontinued | Dosage (if known) |
|---|---|---|---|
| | | | mg |
| | | | mg |

Did the case-patient receive aspirin or other non-steroidal anti-inflammatory drugs (NSAIDs)?

□ Yes □ No □ Unknown

If yes, complete table below

| Drug | Date Initiated | Date Discontinued | Dosage (if known) |
|---|---|---|---|
| | | | mg |
| | | | mg |

Was the case-patient admitted to an intensive care unit (ICU)?

□ Yes □ No □ Unknown

Did this case-patient receive mechanical ventilation?

□ Yes □ No □ Unknown

Did the case-patient have acute respiratory distress syndrome (ARDS)?

□ Yes □ No □ Unknown

What was the outcome for the case-patient?

□ Alive □ Died □ Unknown

If the patient is ALIVE, what is the current disposition of the case-patient?

□ Still hospitalized □ Discharged to home □ Discharged to nursing care facility (specify name) ___________________

□ Unknown □ Other (specify) ___________________

If the patient DIED, please list date of death _______________________(DD/MM/YYYY)

List the ICD-9CM diagnoses at ADMISSION and for each indicate if the diagnosis is a new diagnosis.

1. _ _ _. _ _ □ New □ Unknown 4. _ _ _. _ _ □ New □ Unknown
2. _ _ _. _ _ □ New □ Unknown 5. _ _ _. _ _ □ New □ Unknown
3. _ _ _. _ _ □ New □ Unknown 6. _ _ _. _ _ □ New □ Unknown

List the ICD-10 diagnoses at ADMISSION and for each indicate if the diagnosis is a new diagnosis.

1. _ _ _. _ _ □ New □ Unknown 4. _ _ _. _ _ □ New □ Unknown
2. _ _ _. _ _ □ New □ Unknown 5. _ _ _. _ _ □ New □ Unknown
3. _ _ _. _ _ □ New □ Unknown 6. _ _ _. _ _ □ New □ Unknown

List the ICD-9CM diagnoses at discharge and for each indicate if the diagnosis is a new sequelae of this hospitalization

1. _ _ _. _ _ □ New □ Unknown 4. _ _ _. _ _ □ New □ Unknown
2. _ _ _. _ _ □ New □ Unknown 5. _ _ _. _ _ □ New □ Unknown
3. _ _ _. _ _ □ New □ Unknown 6. _ _ _. _ _ □ New □ Unknown

List the ICD-10 diagnoses at discharge and for each indicate if the diagnosis is a new sequelae of this hospitalization

1. _ _ _. _ _ ☐ New ☐ Unknown 4. _ _ _. _ _ ☐ New ☐ Unknown
2. _ _ _. _ _ ☐ New ☐ Unknown 5. _ _ _. _ _ ☐ New ☐ Unknown
3. _ _ _. _ _ ☐ New ☐ Unknown 6. _ _ _. _ _ ☐ New ☐ Unknown

If ICD-9CM or ICD-10 diagnoses at ADMISSION are <u>not available</u>, write in diagnosis and indicate if the diagnosis is a <u>new diagnosis</u>.

1. __________________________ ☐ New ☐ Unk 4. __________________________ ☐ New ☐ Unk
2. __________________________ ☐ New ☐ Unk 5. __________________________ ☐ New ☐ Unk
3. __________________________ ☐ New ☐ Unk 6. __________________________ ☐ New ☐ Unk

If ICD-9CM or ICD-10 diagnoses at DISCHARGE are <u>not available</u>, write in diagnosis and indicate if the diagnosis is a <u>new sequelae of this hospitalization</u>.

1. __________________________ ☐ New ☐ Unk 4. __________________________ ☐ New ☐ Unk
2. __________________________ ☐ New ☐ Unk 5. __________________________ ☐ New ☐ Unk
3. __________________________ ☐ New ☐ Unk 6. __________________________ ☐ New ☐ Unk

**Medical History-*Laboratory and Diagnostic Testing***

Did the case-patient have a chest x-ray or chest CT scan performed?

☐ Yes ☐ No ☐ not performed ☐ Unknown

If YES, which test was performed? (check all that apply)

☐ Chest CT ☐ Chest X-ray

If either test was performed, what was the result?

☐ Normal ☐ Abnormal ☐ Unknown

If abnormal, was there evidence of pneumonia?

☐ Yes ☐ No ☐ Unknown

Did the case-patient have a CT scan/MRI of the head or brain?

☐ Yes ☐ No ☐ not performed ☐ Unknown

If YES, were there any acute neurologic abnormalities?

☐ Yes ☐ No ☐ Unknown

List the following laboratory test results <u>UPON initial admission</u>:

White blood cell (WBC) count __________________ ☐ Unknown
Lymphocyte count __________________ ☐ Unknown
Neutrophil count __________________ ☐ Unknown
Platelet count __________________ ☐ Unknown

Did the patient have any of the following laboratory abnormalities <u>at any time during</u> the hospitalization?

Leukopenia (white blood cell count <5,000 leukocytes/mm3)

☐ Yes ☐ No ☐ Unknown

Lymphopenia (total lymphocytes <800/mm3 or lymphocytes <15% of total WBC)

☐ Yes ☐ No ☐ Unknown

Thrombocytopenia (total platelets <150,000/mm3)

☐ Yes ☐ No ☐ Unknown

Were bacterial cultures performed?

☐ Yes ☐ No ☐ Unknown

If YES, were any positive?

If positive, complete table below

| Site (Urine, Blood, CSF, Pleural, Ascitic) | Date Performed | Date Positive | Organism grown |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Were non-influenza viral tests performed?

☐ Yes ☐ No ☐ Unknown

If yes, complete table below

| Site (Urine, Blood, CSF, Pleural, Ascitic) | Date Performed | Result | Organism |
|---|---|---|---|
| | | | |
| | | | |

Influenza Specific Diagnostic tests:

Test 1

Specimen type:

☐ NP swab ☐ NP aspirate ☐ Nasal swab ☐ Nasal aspirate ☐ Sputum

☐ Oropharyngeal swab ☐ Endotracheal aspirate ☐ Chest tube fluid

☐ Broncheoalveolar lavage specimen (BAL) ☐ Serum

☐ Other

Date collected: __/__/__

Test type and result: (check all boxes that apply)

| | RT-PCR<br>Yes or No | Direct fluorescent antibody (DFA) | Viral culture | Rapid antigen test | CDC<br>RT-PCR |
|---|---|---|---|---|---|
| Influenza A | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |
| H1 | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |
| H3 | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |
| H5 | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |
| H7 | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |
| Influenza B | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |

Test Location if not Hospital Laboratory______________________

Test 2

Specimen type:

☐ NP swab ☐ NP aspirate ☐ Nasal swab ☐ Nasal aspirate ☐ Sputum

☐ Oropharyngeal swab ☐ Endotracheal aspirate ☐ Chest tube fluid

☐ Broncheoalveolar lavage specimen (BAL) ☐ Serum

☐ Other

Date collected: __/__/__

Test type and result: (check all boxes that apply)

| | RT-PCR<br>Yes or No | Direct fluorescent antibody (DFA) | Viral culture | Rapid antigen test | CDC<br>RT-PCR |
|---|---|---|---|---|---|
| Influenza A | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |
| H1 | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |
| H3 | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |
| H5 | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |
| H7 | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |
| Influenza B | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |

Test Location if not Hospital Laboratory______________________

Test 3

Specimen type:

☐ NP swab ☐ NP aspirate ☐ Nasal swab ☐ Nasal aspirate ☐ Sputum

☐ Oropharyngeal swab ☐ Endotracheal aspirate ☐ Chest tube fluid

☐ Broncheoalveolar lavage specimen (BAL) ☐ Serum

☐ Other

Date collected: __/__/__

Test type and result: (check all boxes that apply)

| | RT-PCR<br>Yes or No | Direct fluorescent antibody (DFA) | Viral culture | Rapid antigen test | CDC<br>RT-PCR |
|---|---|---|---|---|---|
| Influenza A | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |
| H1 | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |
| H3 | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |
| H5 | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |
| H7 | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |
| Influenza B | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested | ☐ Negative<br>☐ Positive<br>☐ Inconclusive<br>☐ Pending<br>☐ Not tested |

Test Location if not Hospital Laboratory______________________

**Specimen Tracking**

Indicate when and what type of specimens (including sera) were sent to CDC and CDCID number, if known

__/__/__ Specimen type _________________CDCID#_________________

__/__/__ Specimen type _________________CDCID#_________________

__/__/__ Specimen type _________________CDCID#_________________