

MERSS ID # _____

Influenza A(H1N1) (formerly 'swine flu') Case Report Form
(FAX to: OR 410-669-4215)

State EPI ID # (epidemiology ID) _____

CDC EPI ID # _____

State lab specimen ID #1 _____

CDC lab specimen ID #1 _____

State lab specimen ID #2 _____

CDC lab specimen ID #2 _____

CDC (lab) unique ID # _____

Reported by:

State: Maryland

County: _____

Date reported to state/local health department

/ /

Name of Person Reporting: Last Name: _____ First Name: _____

Phone Number : () - Fax Number : () - E-Mail: _____

At the time of this report, is the case:

- Not a Case Suspect Probable Confirmed Unclassified

(please see: www.cdc.gov/swineflu for case definitions)

Patient Demographic Data:

Last Name: _____ First Name: _____

Address _____

Phone number () -

Date of Birth (mm/dd/yy): / /

- Race: American Indian/Alaska Native White
 Asian Black
 Native Hawaiian/Other Pacific Islander Multiracial

Ethnicity: Hispanic Non-Hispanic

Sex: Male Female

If Female, is the patient pregnant? Yes (weeks pregnant) _____ No Unknown

Clinical Data:

Date of symptom onset (mm/dd/yy): / /

Signs and symptoms: (check all that apply)

- Fever >37.8 C (100 F) _____ T max Sore throat
 Feverish but temperature not taken Conjunctivitis
 Cough Shortness of breath
 Headache Diarrhea
 Seizures Vomiting
 Rhinorrhea Other, specify _____

Was the patient hospitalized? Yes No Unknown

Was the patient admitted to the intensive case unit? Yes No Unknown

Did the patient require mechanical ventilation? Yes No Unknown

Did the patient die as a result of this illness? Yes No Unknown

MERSS ID # _____

Influenza testing

Test 1 Date collected (mm/dd/yy): ____ / ____ / ____ State Lab Specimen1 ID: _____

Specimen Type	Test Type	Results	Influenza Type/Subtype
_____ Enter specimen code	<input type="checkbox"/> RT-PCR/PCR <input type="checkbox"/> DFA/IFA <input type="checkbox"/> Viral culture <input type="checkbox"/> HI <input type="checkbox"/> Rapid test <input type="checkbox"/> Immunohistochemistry <input type="checkbox"/> Other	<input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> indeterminate	<input type="checkbox"/> flu A <input type="checkbox"/> flu B <input type="checkbox"/> flu A/H1 <input type="checkbox"/> flu A/H3 <input type="checkbox"/> flu A unsubtypeable <input type="checkbox"/> flu A swine H1

Specimen code and type:

- | | | |
|------------------------------|--|-----------------------|
| 1. Nasopharyngeal swab | 7. Bronchoalveolar lavage specimen (BAL) | 13. Pleural fluid |
| 2. Nasopharyngeal aspirate | 8. Sputum | 14. Peritoneal fluid |
| 3. Oropharyngeal/throat swab | 9. Cerebrospinal fluid (CSF) | 15. Pericardial fluid |
| 4. Nasal aspirate/swab | 10. Tissue | 16. Chest fluid |
| 5. Endotracheal aspirate | 11. Stool | 17. Other |
| 6. Serum | 12. Urine | |

Test 2 Date collected (mm/dd/yy): ____ / ____ / ____ State Lab Specimen2 ID: _____

Specimen Type	Test Type	Results	Influenza Type/Subtype
_____ Enter specimen code	<input type="checkbox"/> RT-PCR/PCR <input type="checkbox"/> DFA/IFA <input type="checkbox"/> Viral culture <input type="checkbox"/> HI <input type="checkbox"/> Rapid test <input type="checkbox"/> Immunohistochemistry <input type="checkbox"/> Other	<input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> indeterminate	<input type="checkbox"/> flu A <input type="checkbox"/> flu B <input type="checkbox"/> flu A/H1 <input type="checkbox"/> flu A/H3 <input type="checkbox"/> flu A unsubtypeable <input type="checkbox"/> flu A swine H1

Specimen code and type:

- | | | |
|------------------------------|--|-----------------------|
| 1. Nasopharyngeal swab | 7. Bronchoalveolar lavage specimen (BAL) | 13. Pleural fluid |
| 2. Nasopharyngeal aspirate | 8. Sputum | 14. Peritoneal fluid |
| 3. Oropharyngeal/throat swab | 9. Cerebrospinal fluid (CSF) | 15. Pericardial fluid |
| 4. Nasal aspirate/swab | 10. Tissue | 16. Chest fluid |
| 5. Endotracheal aspirate | 11. Stool | 17. Other |
| 6. Serum | 12. Urine | |

Specimens sent to CDC

Indicate when and what type of specimens (including sera) were sent to CDC and specimen ID

- Date: ____/____/2009 Specimen type (enter specimen code) ____, State Lab Specimen ID A: _____
- Date: ____/____/2009 Specimen type (enter specimen code) ____, State Lab Specimen ID B: _____
- Date: ____/____/2009 Specimen type (enter specimen code) ____, State Lab Specimen ID C: _____

Specimen code and type:

- | | | |
|------------------------------|--|-----------------------|
| 1. Nasopharyngeal swab | 7. Bronchoalveolar lavage specimen (BAL) | 13. Pleural fluid |
| 2. Nasopharyngeal aspirate | 8. Sputum | 14. Peritoneal fluid |
| 3. Oropharyngeal/throat swab | 9. Cerebrospinal fluid (CSF) | 15. Pericardial fluid |
| 4. Nasal aspirate/swab | 10. Tissue | 16. Chest fluid |
| 5. Endotracheal aspirate | 11. Stool | 17. Other |
| 6. Serum | 12. Urine | |

MERSS ID # _____

Treatment:

Did the patient receive antiviral medications?

- Yes No Unknown

If yes, complete table below

Drug	Date Initiated	Date Discontinued	Dosage (if known)
Oseltamivir(Tamiflu®)			
Zanamivir(Relenza®)			
Rimantidine			
Amantadine			
Other _____			

Epidemiologic Risk Factors

Did the patient travel to Mexico since March 15?

- Yes, if so, what day did they return to Maryland? _____ No Unknown

The following questions concern **the 7 days prior to illness onset:**

Did the patient travel outside of Maryland?

- Yes, if so, where? _____ No Unknown

Did the patient have close contact (within 2 meters (6 feet)) with a person (e.g. caring for, speaking with, or touching) who is a **confirmed** swine influenza case*?

- Yes No Unknown

Did the patient have close contact (within 2 meters (6 feet)) with a person (e.g. caring for, speaking with, or touching) who is a **suspected or probable** swine influenza case*?

- Yes No Unknown

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

- Yes No Unknown

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

- Yes No Unknown

What is the patient's occupation?

- Health care worker
 Teacher/works in a school
 Daycare provider
 Other _____

Has the patient had family members or close contacts with pneumonia or influenza-like illness?

- Yes No Unknown

MERSS ID # _____

Household Transmission (*A household member is anyone including the case-patient with at least one overnight stay +/-7days from illness onset*)

How many people live in the household (*include patient in this number*)? _____

For each person in the household, besides the patient, record age, check applicable symptoms if present anytime from 7 days before to 7 days after the patient's onset date, and record intital symptom onset date

Person #	Code*	Age (years)	No symptoms	Feverish	Max temp >37.8C or >100 F	Cough	Sore throat	Runny nose	Diarrhea	Onset date
1			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/2009
2			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/2009
3			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/2009
4			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/2009
5			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/2009
6			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/2009
7			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/2009
8			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/2009
9			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/2009
10			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/2009

*Use to complete the relationship of the household member to the patient: 1=spouse, 2=mother, 3=father, 4=child, 5=sister, 6=brother, 7=cousin, 8=aunt, 9=uncle, 10=grandmother, 11=grandfather, 12=not related, 19=other

If any of the patient's household members been tested for influenza, please complete contact tracing form for each household member.

* Please refer to www.cdc.gov/swineflu for case definition