

North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

INFLUENZA, NOVEL VIRUS INFECTION
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 75

ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease.
Enter all information from this form into the NC EDSS question packages.

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name, First, Middle, Suffix, Maiden/Other, Alias, Birthdate (mm/dd/yyyy), SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Table with 8 columns: Specimen Date, Specimen #, Specimen Source, Type of Test, Test Result(s), Description (comments), Result Date, Lab Name—City/State

CLINICAL FINDINGS
Is/was patient symptomatic for this disease?
If yes, symptom onset date (mm/dd/yyyy):
Fever, Cough, Sore throat, Fatigue or malaise or weakness, Chills or rigors, Dehydration, Shock, Altered mental status, Coma, Headache, Meningitis, Encephalitis, Encephalopathy, Seizures / convulsions, Muscle aches / pains (myalgias), Myositis, Conjunctivitis, Runny nose and/or teary eyes (coryza), Wheezing, Shortness of breath/difficulty breathing/respiratory distress, Acute Respiratory Distress Syndrome (ARDS)

Did the patient have a chest x-ray?
If yes, describe (check all that apply)
Normal, Infiltrate, Diffuse infiltrates/findings suggestive of ARDS, Pleural effusion, Other
Pneumonia, Cardiac arrhythmias or cardiac arrest, Myocarditis, Nausea, Vomiting, Abdominal pain or cramps, Diarrhea, Elevated liver enzymes, Bacteremia, Septicemia / sepsis, Thrombocytopenia, Leukopenia, Anemia, Other symptoms, signs, clinical findings, or complications consistent with this illness

PREDISPOSING CONDITIONS
Any immunosuppressive conditions?
Specify

TREATMENT
Did the patient receive an antiviral for this illness?
Specify antiviral name: Amantadine (Symmetrel), Oseltamivir (Tamiflu), Rimantadine (Flumadine), Zanamivir (Relenza), Other, Unknown
Date antiviral treatment began:
Number of days taken:
Was antiviral prophylaxis given prior to illness onset?
If yes, specify:

REASON FOR TESTING
Why was the patient tested for this condition?
Symptomatic of disease, Exposed to organism causing this disease (asymptomatic), Exposed to organism causing this disease (symptomatic), Household / close contact to a person reported with this disease, Healthcare exposure, Other, specify, Unknown

HOSPITALIZATION INFORMATION
Was patient hospitalized for this illness >24 hours?
Hospital name:
City, State:
Hospital contact name:
Telephone:
Admit date (mm/dd/yyyy):
Discharge date (mm/dd/yyyy):
Number of days hospitalized
at time of report:

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? Y N U
Check all that apply:
 Work Sexual behavior
 Child care Blood and body fluid
 School Other, specify _____

Date control measures issued: ____/____/____
Date control measures ended: ____/____/____
Was patient compliant with control measures? Y N U

Did local health director or designee implement additional control measures? (example: cohort classrooms, special cleaning, active surveillance, etc.)..... Y N U
If yes, specify: _____

Were written isolation orders issued?.. Y N U
If yes, where was the patient isolated? _____

Date isolation started: ____/____/____
Date isolation ended: ____/____/____
Was the patient compliant with isolation? Y N U

Were written quarantine orders issued? Y N U
If yes, where was the patient quarantined? _____

Date quarantine started: ____/____/____
Date quarantine ended: ____/____/____
Was the patient compliant with quarantine?..... Y N U

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? Y N U
Died?..... Y N U
Died from this illness? Y N U
Date of death (mm/dd/yyyy): ____/____/____

Autopsy performed? Y N U
Patient autopsied in NC? Y N U
County of autopsy: _____
 Autopsied outside NC, specify where: _____

Source of death information (select all that apply):
 Death certificate
 Autopsy report final conclusions
 Hospital/physician discharge summary
 Other _____

TRAVEL & IMMIGRATION

The patient is:
 Resident of NC
 Resident of another state or US territory
 Foreign Visitor
 Refugee
 Recent Immigrant
 Foreign Adoptee
 None of the above

Did patient have a travel history during the 7 days prior to onset of symptoms? Y N U

List travel dates and destinations:
From ____/____/____ to ____/____/____

Modes of transportation:
 Airplane Bus/Taxi/Shuttle
 Train On Foot
 Ship/Boat/Ferry Other, specify: _____
 Automobile/Motorcycle

Provide transportation details:
Date of travel ____/____/____
Departed _____
Airline/Railroad/Ship/Busline _____
Arrived _____
Flight #/Route # _____
Seat #/Cabin # _____

Date of travel ____/____/____
Departed _____
Airline/Railroad/Ship/Busline _____
Arrived _____
Flight #/Route # _____
Seat #/Cabin # _____

Date of travel ____/____/____
Departed _____
Airline/Railroad/Ship/Busline _____
Arrived _____
Flight #/Route # _____
Seat #/Cabin # _____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? Y N U

List persons and contact information:

Additional travel information: _____

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? Y N U
Name of child care provider: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Contact name: _____
Telephone: (____) _____

Patient a child care worker or volunteer in child care? Y N U
Name of child care provider: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Contact name: _____
Telephone: (____) _____

Patient a parent or primary caregiver of a child in child care? Y N U
Name of child care provider: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Contact name: _____
Telephone: (____) _____

Is patient a student? Y N U
Type of school:
 NC Public School (preK-12)
 NC Private School (preK-12)
 Other School (preK-12)
 Community College/College/University
 Other academic institution (i.e. trade school, professional school, etc)

Name: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Contact name: _____
Telephone: (____) _____
Specify grade: _____

Is patient a school WORKER/VOLUNTEER in NC school setting? Y N U
Type of school
 NC Public School (preK-12)
 NC Private School (preK-12)
 Other School (preK-12)
 Community College/College/University
 Other academic institution (i.e. trade school, professional school, etc)

Name: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Telephone: (____) _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
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BEHAVIORAL RISK & CONGREGATE LIVING

During the 7 days prior to onset of symptoms did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? Y N U

Name of facility: _____
Dates of contact: _____

During the 7 days prior to onset of symptoms, did the patient attend social gatherings or crowded settings? Y N U

If yes, specify: _____

In what setting was the patient most likely exposed?

- | | |
|---|--|
| <input type="checkbox"/> Restaurant | <input type="checkbox"/> Place of Worship |
| <input type="checkbox"/> Home | <input type="checkbox"/> Outdoors, including woods or wilderness |
| <input type="checkbox"/> Work | <input type="checkbox"/> Athletics |
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Farm |
| <input type="checkbox"/> School | <input type="checkbox"/> Pool or spa |
| <input type="checkbox"/> University/College | <input type="checkbox"/> Pond, lake, river or other body of water |
| <input type="checkbox"/> Camp | <input type="checkbox"/> Hotel / motel |
| <input type="checkbox"/> Doctor's office/ Outpatient clinic | <input type="checkbox"/> Social gathering, other than listed above |
| <input type="checkbox"/> Hospital In-patient | <input type="checkbox"/> Travel conveyance (airplane, ship, etc.) |
| <input type="checkbox"/> Hospital Emergency Department | <input type="checkbox"/> International |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Community |
| <input type="checkbox"/> Long-term care facility /Rest Home | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Military | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Prison/Jail/Detention Center | |

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 7 days prior to onset of symptoms, did the patient have:

Blood or body fluid exposures? Y N U

Specify: _____

Any human saliva/oral secretions exposure (e.g. shared water bottle, cigarettes, eating utensils, kissing)? Y N U

Specify: _____

Any of the following health care exposures?

- Emergency Department (not hospitalized)
 Hospitalized
 Other

Visit / admit date (mm/dd/yyyy): ____/____/____

Facility name _____

Has patient been discharged? Y N U

Discharge date (mm/dd/yyyy): ____/____/____

Was facility notified regarding ill patient?

- Yes No Unknown Not applicable

Name of person notified _____

Date notified (mm/dd/yyyy): ____/____/____

Worked or volunteered in health care, lab, or clinical setting

Specify occupation: _____

Facility name _____

City _____ State _____

Country _____

- No
 Unknown

Notes:

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U
If yes, specify: _____

FOOD RISK AND EXPOSURE

During the 7 days prior to onset of symptoms, did the patient do any of the following:

Handle raw poultry? Y N U

Specify type of poultry: _____

Obtained from (name & location): _____

Brand name (if applicable) _____

Handled on (mm/dd/yyyy) ____/____/____

Until (mm/dd/yyyy) ____/____/____

Frequency:

- Once
 Multiple times within this time period
 Daily

Handle shell eggs? Y N U

Obtained from (name & location): _____

Brand name (if applicable) _____

Handled on (mm/dd/yyyy) ____/____/____

Until (mm/dd/yyyy) ____/____/____

Frequency:

- Once
 Multiple times within this time period
 Daily

Eat any poultry / poultry product? Y N U

Specify type of poultry: _____

Was this food rare, undercooked, or raw? Y N U

Consumed on what dates: _____

Frequency food consumed:

- Once
 Multiple times within this time period
 Daily

OUTDOOR EXPOSURE

During the 7 days prior to onset of symptoms, did the patient participate in any outdoor activities? Y N U

Was patient exposed to wild animals? Y N U

Specify:

Game bird(s)

Specify game bird(s): _____

Waterfowl (wild)

Specify waterfowl: _____

Other

Unknown animal species

Animal was

- Dead Alive Sick Unknown

Dates of exposure: _____

____/____/____ until ____/____/____

What was location of the exposure? _____

Did the patient skin/eviscerate (gut) wild animal or have contact with wild animal carcass? Y N U

Did patient work in wildlife law enforcement? Y N U

Did patient work in wildlife rehabilitation? Y N U

ANIMAL EXPOSURE

During the 7 days prior to onset of symptoms did the patient have exposure to animals (includes animal tissues, animal products or animal excreta)? Y N U

Did patient own, work at, or visit a pet store, animal shelter, and/or animal breeder/wholesaler/distributor? Y N U

Specify: Owned Worked Visited

Exposed on (mm/dd/yyyy) ____/____/____

Until (mm/dd/yyyy) ____/____/____

Frequency:

- Once
 Multiple times within this time period
 Daily

Did the patient handle any animals? Y N U

Species: _____

Did it/they appear sick? Y N U

Did patient work with animal importation? Y N U

Business address: _____

Species: _____

Country of origin: _____

Shipping port of origin (if known): _____

Did patient / household contact work at, live on, or visit a farm, ranch, or dairy? Y N U

Specify:

- Worked
 Lived on
 Lived with someone who worked/visited
 Visited

Farm/ranch/dairy name _____

Street address _____

City _____

State _____ Zip code _____

County _____

Telephone _____

Exposed on (mm/dd/yyyy) ____/____/____

Until (mm/dd/yyyy) ____/____/____

Was patient exposed to animals associated with agriculture or aviculture (domestic/semi-domestic animals)? Y N U

Specify animals/birds: _____

Exposed on (mm/dd/yyyy) ____/____/____

Until (mm/dd/yyyy) ____/____/____

Frequency:

- Once
 Multiple times within this time period
 Daily

Did patient have exposure to animal excreta (urine or feces)? Y N U

Specify: _____

Exposed on (mm/dd/yyyy) ____/____/____

Until (mm/dd/yyyy) ____/____/____

Did patient have exposure to bird feathers or feather dust? Y N U

Specify: _____

Did patient work at or visit a slaughterhouse (abattoir), meat-packing plant, poultry or wild game processing facility? Y N U

Name of facility: _____

Address: _____

Telephone: _____

Species slaughtered: _____

Has patient otherwise slaughtered animals or been a butcher, meat-cutter or meat processor? Y N U

Address: _____

Species: _____

CONTINUED ON NEXT PAGE

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

ANIMALS EXPOSURE (CONTINUED)

Did the patient work at or visit a fair with livestock or a petting zoo? Y N U

Provide address/contact information:

Specify contact/exposure to any agricultural livestock present at facility: _____

Did patient work at or visit a zoo, zoological park or aquarium? Y N U

Provide address:

Specify contact/exposure to any agricultural livestock present at facility: _____

Did the patient own, work at, or visit a private or public aviary (bird exhibit) or live bird market? Y N U

Provide address:

Specify birds present: _____

Did patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory? Y N U

Specify which setting:
 Animal diagnostic (pathology) laboratory
 Animal laboratory/animal research
 Biomedical laboratory
 Veterinary medical practice
 Provide name & address of facility:

Did patient work with vaccines for zoonotic agents? Y N U

Specify vaccine(s): _____

Did patient necropsy animals? Y N U

Specify species: _____

Did patient work with zoonotic agents? Y N U

Specify agent(s): _____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U

Date of interview (mm/dd/yyyy): ____/____/____

Were interviews conducted with others? Y N U

Who was interviewed? _____

Were health care providers consulted? Y N U

Who was consulted? _____

Medical records reviewed (including telephone review with provider/office staff)? Y N U

Specify reason if medical records were not reviewed: _____

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

In NC
City _____

County _____

Outside NC, but within US

City _____

State _____

County _____

Outside US

City _____

Country _____

Unknown

Is the patient part of an outbreak of this disease? Y N

Notes:

VACCINE

Has patient / contact ever received vaccine for a novel influenza virus? Y N U

Specify: _____

Did the patient receive any influenza vaccine during the current season (before illness)? Y N U

Specify: _____

Did the patient receive any influenza vaccine in previous seasons? Y N U

NOVEL influenza A virus infection

2007 CDC Case Definition

Clinical Presentation

An illness compatible with influenza virus infection.

Laboratory Evidence

A human case of infection with an influenza A virus subtype that is different from currently circulating human influenza H1 and H3 viruses. Novel subtypes include, but are not limited to, H2, H5, H7, and H9 subtypes. Influenza H1 and H3 subtypes originating from a non-human species or from genetic reassortment between animal and human viruses are also novel subtypes. Novel subtypes will be detected with methods available for detection of currently circulating human influenza viruses at state public health laboratories (e.g., real-time reverse transcriptase polymerase chain reaction [RT-PCR]). Non-human influenza viruses include avian subtypes (e.g., H5, H7, or H9 viruses), swine and other mammalian subtypes. Confirmation that an influenza A virus represents a novel virus will be performed by CDC's influenza laboratory.

Criteria for epidemiologic linkage: a) the patient has had contact with one or more persons who either have or had the disease and b) transmission of the agent by the usual modes of transmission is plausible. A case may be considered epidemiologically linked to a laboratory-confirmed case if at least one case in the chain of transmission is laboratory confirmed.

Case Classification

Confirmed: A case of human infection with a novel influenza A virus confirmed by CDC's influenza laboratory.

Probable: A case meeting the clinical criteria and epidemiologically linked to a confirmed case, but for which no laboratory testing for influenza virus infection has been performed.

Suspected: A case meeting the clinical criteria, pending laboratory confirmation. Any case of human infection with an influenza A virus that is different from currently circulating human influenza H1 and H3 viruses is classified as a suspected case until the confirmation process is complete.

Comment

For additional information about influenza or influenza surveillance, refer to CDC the CDC Influenza web site: www.cdc.gov/flu/.

On December 13, 2006, the United States formally accepted the revision of the International Health Regulations, referred to as IHR (2005) (<http://www.hhs.gov/news/press/2006pres/20061213.html>). The IHR (2005) are an international legal instrument that governs the roles of the WHO and its member countries in identifying and responding to and sharing information about public health emergencies of international concern (http://www.who.int/csr/ihr/IHRWHA58_3-en.pdf). The updated rules are designed to prevent and protect against the international spread of diseases, while minimizing interference with world travel and trade. The revised regulations add human infections with new influenza strains to the list of conditions that Member States must immediately report to WHO. An outbreak of infections with a new influenza A virus that demonstrates human-to-human transmission could signal the beginning of the next pandemic. Robust epidemiologic and laboratory

surveillance systems are required for a coordinated public health response to infections with a novel influenza virus subtype. Early detection of an influenza virus with pandemic potential will permit identification of viral characteristics (e.g., genetic sequence, antiviral susceptibility, and virulence) that will affect clinical management and public health response measures. It should also facilitate development of a virus-specific vaccine and testing strategies.

All state public health laboratories have the capacity to test respiratory specimens for influenza viruses with sensitive and specific assays that can detect human and non-human influenza A viruses. They also have the capacity to subtype currently circulating human influenza A H1, H3, and avian H5 (Asian lineage) viruses. The detection or confirmation by a state public health laboratory of an influenza A virus that is unsubtypeable with standard methods (e.g., real-time RT-PCR assays for human influenza A(H3) or (H1) viruses), or a non-human influenza virus (e.g., H5) from a human specimen, could be the initial identification of a virus with pandemic potential. Prompt notification of CDC by a state epidemiologist in conjunction with the public health laboratory will permit rapid confirmation of results and reporting to WHO. In addition, it will aid prompt viral characterization, and the development of virus-specific diagnostic tests.