

# CASE REPORT FORM

# Non seasonal influenza

Non seasonal influenza _____		EpiSurv No. _____	
<b>Disease Name</b>			
<input type="radio"/> Non seasonal influenza A (H1N1)			
<b>Reporting Authority</b>			
Name of Public Health Officer responsible for case _____			
<b>Notifier Identification</b>			
<b>Reporting source*</b> <input type="radio"/> General Practitioner <input type="radio"/> Hospital-based Practitioner <input type="radio"/> Laboratory <input type="radio"/> Self-notification <input type="radio"/> Outbreak Investigation <input type="radio"/> Other			
Name of reporting source _____		Organisation _____	
Date reported* _____		Contact phone _____	
Usual GP _____		Practice _____	
GP/Practice address Number _____		Street _____	
Town/City _____		Suburb _____	
Post Code _____		<input type="checkbox"/> GeoCode _____	
<b>Case Identification</b>			
Name of case* Surname _____		Given Name(s) _____	
NHI number* _____		Email _____	
Current address* Number _____		Street _____	
Town/City _____		Suburb _____	
Post Code _____		<input type="checkbox"/> GeoCode _____	
Phone (home) _____		Phone (work) _____	
		Phone (other) _____	
<b>Case Demography</b>			
Location TA* _____		DHB* _____	
Date of birth* _____		OR Age _____	
		<input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	
Sex* <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Indeterminate <input type="radio"/> Unknown			
Occupation* _____			
Occupation location <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school			
Name _____			
Address Number _____		Street _____	
Town/City _____		Suburb _____	
Post Code _____		<input type="checkbox"/> GeoCode _____	
Alternative location <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school			
Name _____			
Address Number _____		Street _____	
Town/City _____		Suburb _____	
Post Code _____		<input type="checkbox"/> GeoCode _____	
Ethnic group case belongs to* (tick all that apply)			
<input type="checkbox"/> NZ European	<input type="checkbox"/> Maori	<input type="checkbox"/> Samoan	<input type="checkbox"/> Cook Island Maori
<input type="checkbox"/> Niuean	<input type="checkbox"/> Chinese	<input type="checkbox"/> Indian	<input type="checkbox"/> Tongan
<input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan)		*(specify) _____	

**Basis of Diagnosis****CLINICAL CRITERIA (refer to the current case definition)**

Fits clinical description\*  Yes  No  Unknown

Pneumonia\*  Yes  No  Unknown

Respiratory Distress Syndrome (ARDS)\*  Yes  No  Unknown

Ventilation required\*  Yes  No  Unknown

**LABORATORY CRITERIA (refer to the current case definition)**

Meets laboratory criteria for disease\*  Yes  No  Unknown

**STATUS\***  Under investigation  Probable  Confirmed  Not a case

**Clinical Course and Outcome**

Date of onset\* \_\_\_\_\_  Approximate  Unknown

Hospitalised\*  Yes  No  Unknown

Date hospitalised\* \_\_\_\_\_  Unknown

Hospital\* \_\_\_\_\_

Died\*  Yes  No  Unknown

Date died\* \_\_\_\_\_  Unknown

Was this disease the primary cause of death?\*  Yes  No  Unknown

**Outbreak Details**

Is this case part of an outbreak?  Yes If yes, specify outbreak number \_\_\_\_\_

**Risk Factors****Does the case have any of the following factors that place them at the risk of severe complications?\***

Immunosuppression (inc. cancer, HIV/AIDS, immunosuppressive therapy)	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U	Chronic respiratory conditions (including asthma or COPD)	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U
Cardiac disease	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U	Diabetes mellitus	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U
Haemoglobinopathies	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U	Neurological	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U
Renal failure	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U	Morbid obesity	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U
Metabolic diseases	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U	Pregnancy	<input type="radio"/> Y <input type="radio"/> N <input type="radio"/> U

Is the case a resident of an aged care facility?\*  Yes  No  Unknown

Has the case had regular contact with infants or young children?\*  Yes  No  Unknown

Is the case a healthcare worker?\*  Yes  No  Unknown

If yes, specify \_\_\_\_\_

Other risk factors for disease\* \_\_\_\_\_

**Protective Factors**

Has the case had a seasonal influenza vaccination in the last 12 months?\*  Yes  No  Unknown

Did the case receive anti-virals?\*  Yes  No  Unknown

**Comments**