

AVIAN INFLUENZA (AI) IN HUMANS

(TO BE COMPLETED FOR SUSPECTED AND CONFIRMED CASES)

Case details

Surname	_____	Given name	_____	NDD no.	_____
DOB	__/__/__	Age	___ yrs/___ mths	Sex	M F
Address	_____				
Suburb	_____	Postcode	_____	Telephone	_____
Other contact	_____				
Occupation/school	_____				
Indigenous	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres St Islander <input type="checkbox"/> both Aboriginal and TSI <input type="checkbox"/> Not Indigenous <input type="checkbox"/> not stated	Country of Birth	<input type="checkbox"/> Australia <input type="checkbox"/> Other: <i>specify</i> _____	Language	<input type="checkbox"/> English <input type="checkbox"/> Other: <i>specify</i> _____

Disease

Onset of First Symptoms	__/__/__	Time	_____
Fever >38°C	Y / N / Unknown		
Fever Onset	__/__/__	Time	_____
Cough	Y / N / Unknown	If Yes: Productive / Non-productive	
Difficulty Breathing	Y / N / Unknown		
Headache	Y / N / Unknown		
Myalgia	Y / N / Unknown		
Rhinorrhoea (runny nose)	Y / N / Unknown		
Sore Throat	Y / N / Unknown		
Rigors	Y / N / Unknown		
Vomiting	Y / N / Unknown		
Diarrhoea	Y / N / Unknown		
Conjunctivitis	Y / N / Unknown		
Confusion	Y / N / Unknown		
Other Symptoms	Y / N / Unknown	Details _____	
CXR Performed?	Y / N / Unknown	If Yes, date performed __/__/__	
Description of CXR Findings	_____		
Other Abnormal Findings	_____		
(e.g., white cell count, liver function)	_____		

Laboratory

Lab confirmed	Y N	Specimen	_____	Specimen date/(s)	__/__/__ __/__/__
Organism	_____	ID method	_____		

Notification

First notifier	_____	Telephone	_____	Fax	_____
Notifier type	<input type="checkbox"/> Lab <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital (not lab) <input type="checkbox"/> Other _____	Notified date	__/__/__	Received date	__/__/__
Treating doctor	_____	Telephone	_____	Postcode	_____
Address	_____				
				Fax	_____

Exposure History

Contact with an infectious human case of AI in 10 days before onset Y / N / Unknown

Date of last contact with a case? ___/___/___

Provide details of contact _____
 (name, relationship, dates, duration, closeness of contact) _____

Contact with infected birds in 10 days before onset Y / N / Unknown
 (provide details in the *Travel History section below*)

Contact with AI laboratory samples in 10 days before onset Y / N / Unknown

Date of last contact with such samples? ___/___/___

Travel History

1. ITINERARY

Please supply an itinerary of travel from 10 days before symptom onset to the present. Include visits to both AI-affected and AI-unaffected countries, dates of arrival and departure for each, and flight numbers.

Country Visited	Date & Time of Arrival	Flight Carrier & Number	Date & Time of Departure	Flight Carrier & Number

2. DETAILED HISTORY OF TRAVEL TO AI-AFFECTED COUNTRIES

Attach a separate page for each AI-affected country visited.

Name of Country _____ **Was it a Transit?** Y / N

If in transit, please specify details

Airport _____ **Transit Date/s** _____ **Transit Time (hrs)** _____

Did the case leave the airport during transit? Y / N

Did the case travel within the country? Y / N *If YES, detail all places visited*

Name of Place Visited	Contact with Poultry* (Y/N/U)	Type of Poultry Contact*	Date(s) of Poultry Contact

*e.g., visit to poultry market or poultry farm, residing in a village with large numbers of poultry, travelling on public transport with poultry

Reason for visit:

Business Y / N **Holiday** Y / N **Visit family / friends** Y / N

Other (specify) _____

If holiday, was the case on a tour? Y / N

If YES, name of tour and tour company _____

Dates travelled on tour _____ **to** _____

Other countries visited on tour _____

Hospital Admission History (in Australia)

Hospitalised Y / N / Unknown
Hospital Name _____
Date Admitted ___/___/___
Date Discharged ___/___/___
Treating Doctor Name _____ Position _____
Contact No. _____
Isolation Y / N / Unknown
If Yes, dates of period of isolation ___/___/___ to ___/___/___
ICU Admission Y / N / Unknown
If Yes, dates of ICU stay ___/___/___ to ___/___/___
Mechanical Ventilation Y / N / Unknown
Co-morbidities Y / N / Unknown **If Yes, specify** _____

Vaccination History

Previous Vaccination Against Influenza? Y / N / Unknown
If Yes, most recent year? _____
Previous Vaccination Against Pneumococcus? Y / N / Unknown
If Yes, most recent year? _____

Treatment Details

Antibiotics (please list) _____

Antivirals (please list) _____

Other (please list) _____

Outcome (circle all that apply)

Case Confirmed as AI Y / N
Alternative Diagnosis Made? Y / N **If Yes, specify** _____
If yes, was there supporting microbiological evidence? Y / N / Unknown
Details: _____
Case Recovered? Y / N / Unknown
Case Died? Y / N / Unknown
If yes, was an autopsy conducted? Y / N / Unknown **If yes, results:** _____

Notes _____

Administration

Completed by _____ **Date finalised** ___/___/___ **PHU** _____