CASE REPORT FORM

Avian Influenza

EpiSurv No.

Reporting Authority

Name of Public Health Officer responsible for case

Notifier Identification

Reporting source* ○ General Practitioner ○ Hospital-based Practitioner ○ Laboratory ○ Self-notification ○ Outbreak Investigation ○ Other

Name of reporting source **Organisation**

Date reported* dd/mm/yyyy **Laboratory sample date** dd/mm/yyyy **Contact phone**

Usual GP **Practice** **GP phone**

GP/Practice address Number Street Suburb

Town/City Post Code GeoCode

Case Identification

Name of case* Surname Given Name(s)

NHI number* **Email**

Current address* Number Street Suburb

Town/City Post Code GeoCode

Phone (home) **Phone (work)** **Phone (other)**

Case Demography

Location **TA*** **DHB***

Date of birth* dd/mm/yyyy **OR** **Age** ○ Days ○ Months ○ Years

Sex* ○ Male ○ Female ○ Unknown ○ Other

Occupation*

Occupation location ○ Place of Work ○ School ○ Pre-school

Name

Address Number Street Suburb

Town/City Post Code GeoCode

Alternative location ○ Place of Work ○ School ○ Pre-school

Name

Address Number Street Suburb

Town/City Post Code GeoCode

Ethnic group case belongs to* (tick all that apply)

☐ NZ European ☐ Maori ☐ Samoan ☐ Cook Island Maori

☐ Niuean ☐ Chinese ☐ Indian ☐ Tongan

☐ Other (such as Dutch, Japanese, Tokelauan) *(specify)

EpiSurv No.

Additional Case Information

Usual place of residence if different from current address (on first page)*

Country	Region or province	District or TA equivalent

Basis of Diagnosis

CLINICAL CRITERIA

Fits clinical description* Yes No Unknown

Was the case asymptomatic?* Yes No Unknown

If no, list all symptoms (tick all that apply)*

History of fever/chills | Cough | Sore throat | Runny nose | Shortness of breath

General weakness | Headache | Muscular pain | Chest pain | Joint pain

Nausea/vomiting | Abdominal pain | Diarrhoea | Irritability/confusion | Conjunctivitis

Other symptoms, specify*

Clinical signs (tick all that apply)*

Abnormal lung x-ray findings/pneumonia | Coma/loss of consciousness | Meningitis/encephalitis

LABORATORY CRITERIA

Laboratory confirmation of avian influenza*	Yes	No	Not Done	Awaiting Results
If yes, specify laboratory confirmation method (tick all that apply)*				
Positive PCR test for influenza A	Yes	No	Not Done	Awaiting Results
If yes, subtyping result	H5	H7	H9	Not Done	Awaiting Results
Four-fold or greater rise in HPAI virus-specific neutralising antibodies*	Yes	No	Not Done	Awaiting Results
Whole genome sequencing characterisation of avian influenza	Yes	No	Not Done	Awaiting results
Other positive test (specify*)				

EPIDEMIOLOGICAL CRITERIA

Fits epidemiological criteria?* Yes No Unknown

CLASSIFICATION* Under investigation | Probable | Confirmed | Not a case

ADDITIONAL LABORATORY DETAILS

Organism subtype (eg H and N type/clade)*

Clinical Course and Outcome

Date of onset* dd/mm/yyyy Approximate Unknown

Hospitalised* Yes No Unknown

Date hospitalised* dd/mm/yyyy Unknown

Hospital*

Died* Yes No Unknown

Date died* dd/mm/yyyy Unknown

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

If no, specify the primary cause of death*

EpiSurv No.

Additional Outcome Details

Was the case in ICU?* ○ Yes ○ No ○ Unknown

Ventilation required* ○ Yes ○ No ○ Unknown

Extracorporeal membrane oxygenation required (ECMO)* ○ Yes ○ No ○ Unknown

Outbreak Details

Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?*

☐ Yes **If yes, specify Outbreak No.***

Risk Factors

Was the case overseas during the incubation period for this disease?* ○ Yes ○ No ○ Unknown

If yes, date arrived in New Zealand* dd/mm/yyyy

Specify countries visited (from most recent to least recent)*

Sequence	Country	City/Region	Date Entered	Date Departed
Last:*			dd/mm/yyyy	dd/mm/yyyy
Second Last:*			dd/mm/yyyy	dd/mm/yyyy
Third Last:*			dd/mm/yyyy	dd/mm/yyyy
Fourth Last:*			dd/mm/yyyy	dd/mm/yyyy

During the incubation period, did the case undertake any of the following activities?* (tick all that apply)

Please answer in addition to the occupation question on the first page.

☐ Human healthcare work ☐ Animal healthcare work ☐ Health laboratory work ☐ Animal health laboratory work

If undertaking laboratory work, are avian influenza virus samples handled there? ○ Yes ○ No ○ Unknown

☐ Work or recreation with wild or domestic animals (tick all that apply)

☐ Wild birds ☐ Commercial poultry ☐ Domestic birds ☐ Cats ☐ Other domestic pets

☐ Cattle (beef or dairy) ☐ Marine animals ☐ Other animal (specify)

If yes to any, describe animal contact

During the incubation period, did the case have close contact with a probable or confirmed human case of avian influenza?* ○ Yes ○ No ○ Unknown

If yes, EpiSurv number of probable or confirmed case*

Underlying conditions (tick all that apply)*

☐ Pregnancy If yes, trimester ☐ Post-partum (< 6 weeks)

☐ Cardiovascular disease, including hypertension ☐ Immunodeficiency, including HIV

☐ Diabetes ☐ Renal failure

☐ Liver disease ☐ Chronic lung disease

☐ Chronic neurological or neuromuscular disease ☐ Malignancy

☐ Other underlying condition, specify

Other risk factors for disease*

Protective Factors

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

If yes, specify date of last vaccination* dd/mm/yyyy

Has the case had a pre pandemic influenza vaccination in the last 12 months?* ○ Yes ○ No ○ Unknown

If yes, specify date of last vaccination* dd/mm/yyyy

EpiSurv No.

Management

CASE MANAGEMENT

Was the case advised to isolate for an appropriate period?* ○ Yes ○ No ○ Unknown

If yes, isolation start date* dd/mm/yyyy Isolation end date* dd/mm/yyyy

ANTI-VIRAL STATUS

Did the case receive antivirals?* ○ Yes ○ No ○ Unknown

If yes, provide additional details below:

Purpose of antiviral administration* (tick all that apply)

☐ Post-exposure prophylaxis ☐ Treatment

Medication*	**Date Started**
☐ Oseltamivir phosphate (Tamiflu®)*	dd/mm/yyyy
☐ Baloxavir (Xofluza ®)*	dd/mm/yyyy
☐ Other, specify*	dd/mm/yyyy

Was the prescribed dose of antiviral medication taken every day prior to illness?* ○ Yes ○ No ○ Unknown

If antivirals have not been received, are they planned?* ○ Yes ○ No ○ Unknown

If antiviral treatment was considered but not given, specify reason* (tick all that apply)

☐ Does not meet case definition ☐ Outside treatment window ☐ Person refused ☐ Unknown

☐ Other (specify)

CONTACT MANAGEMENT

Please summarise all high risk contacts of the case

Contact Type*	Number identified	Number counselled	Number with symptoms	Number given post exposure prophylaxis
Household*				
Healthcare setting / laboratory staff*				
Other high risk close contact*				

Comments*