

CASE REPORT FORM

Avian Influenza

	EpiSurv No. <input style="width: 50px;" type="text"/>
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Reporting Authority

Name of Public Health Officer responsible for case

Notifier Identification (i)

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

Name of reporting source **Organisation**

Date reported* **Laboratory sample date** **Contact phone**

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

GP/Practice address Number Street Suburb
GPAddress Town/City Post Code GeoCode

Case Identification (i)

Name of case* Surname Given Name(s)

NHI number* **Email**

Current address* Number Street Suburb
CaseAddress Town/City Post Code GeoCode

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

Case Demography

Location TA* **DHB***

Date of birth* **OR** **Age** AgeUnits Days Months Years

Sex* Sex Male Female Unknown Other

Occupation* (i)

Occupation location PlaceOfWork1Type Place of Work School Pre-school

Name

Address Number Street Suburb
PlaceOfWork1A Town/City Post Code GeoCode
address

Alternative location PlaceOfWork2Type Place of Work School Pre-school

Name

Address Number Street Suburb
PlaceOfWork2 Town/City Post Code GeoCode
Address

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

NZ European Maori EthMaori Samoan Cook Island Maori EthCookIslandMaori
EthNZEuroean EthSamoan

Niuean EthNiuean Chinese EthChinese Indian EthIndian Tongan EthTongan

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

Additional Case Information

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

Country **ResidCountry** Region or province **ResidRegion** District or TA equivalent **ResidDistrict**

Basis of Diagnosis

CLINICAL CRITERIA [i](#)

Fits clinical description* **FitClinDes** Yes No Unknown

Was the case asymptomatic?* **Asymptomatic** Yes No Unknown

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

<input type="checkbox"/> History of fever/chills FeverGT38	<input type="checkbox"/> Cough Cough	<input type="checkbox"/> Sore throat SoreThroat	<input type="checkbox"/> Runny nose RunNose	<input type="checkbox"/> Shortness of breath ShBreath
<input type="checkbox"/> General weakness Weakness	<input type="checkbox"/> Headache Headache	<input type="checkbox"/> Muscular pain PainMusc	<input type="checkbox"/> Chest pain PainChest	<input type="checkbox"/> Joint pain PainJoint
<input type="checkbox"/> Nausea/vomiting NausVom	<input type="checkbox"/> Abdominal pain PainAbdom	<input type="checkbox"/> Diarrhoea Diarrhoea	<input type="checkbox"/> Irritability/confusion IritConfus	<input type="checkbox"/> Conjunctivitis Conjunctvts
<input type="checkbox"/> Other symptoms, specify* OthSymSpec <input type="text"/>				

Clinical signs (tick all that apply)*

<input type="checkbox"/> Abnormal lung x-ray findings/pneumonia LungXray	<input type="checkbox"/> Coma/loss of consciousness Coma	<input type="checkbox"/> Meningitis/encephalitis MeningEnceph
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LABORATORY CRITERIA [i](#)

Laboratory confirmation of avian influenza* **LabConf** Yes No Not Done Awaiting Results

If yes, specify laboratory confirmation method (tick all that apply)*

Positive PCR test for influenza A **PCRFluA** Yes No Not Done Awaiting Results

If yes, subtyping result **FluASubtype** H5 H7 H9 Not Done Awaiting Results

Four-fold or greater rise in HPAI virus-specific neutralising antibodies* **Titre4x** Yes No Not Done Awaiting Results

Whole genome sequencing characterisation of avian influenza **WGSCharm** Yes No Not Done Awaiting results

Other positive test (specify*) **OthPosSpec**

EPIDEMIOLOGICAL CRITERIA [i](#)

Fits epidemiological criteria?* **FitsEpi** Yes No Unknown

CLASSIFICATION* **Status** Under investigation Probable Confirmed Not a case [i](#)

ADDITIONAL LABORATORY DETAILS

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

Clinical Course and Outcome

Date of onset* **OnsetDt** Approximate **OnsetDtApprox** Unknown **OnsetDtUnknown**

Hospitalised* **Hosp** Yes No Unknown

Date hospitalised* **HospDt** Unknown **HospDtUnknown**

Hospital* **HospName**

Died* **Died** Yes No Unknown

Date died* **DiedDt** Unknown **DiedDtUnknown**

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

If no, specify the primary cause of death* **DiedOther**

Additional Outcome Details

- Was the case in ICU?*** ICU Yes No Unknown
- Ventilation required*** VentReqd Yes No Unknown
- Extracorporeal membrane oxygenation required (ECMO)*** 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)?*

Outbrk YesIf yes, specify Outbreak No.* OutbrkNo **Risk Factors**

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

If yes, date arrived in New Zealand* DtArrived

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

Sequence	Country	City/Region	Date Entered	Date Departed
Last:*	LastCountry	LastRegion	LastDtEntered	LastDtDeparted
Second Last:*	SecCountry	SecRegion	SecDtEntered	SecDtDeparted
Third Last:*	ThirdCountry	ThirdRegion	ThirdDtEntered	ThirdDtDeparted
Fourth Last:*	FourthCountry	FourthRegion	FourthDtEntered	FourthDtDeparted

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 HumHCare Animal healthcare work AnimHCare Health laboratory work HumHLab Animal health laboratory work AnimHLab

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

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

- Wild birds WildBirds Commercial poultry ComPoultry Domestic birds DomBirds Cats Cats Other domestic pets OtherPets

- Cattle (beef or dairy) Cattle Marine animals MarineAn Other animal (specify) OthAnSpec

If yes to any, describe animal contact AnContSpec

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

If yes, EpiSurv number of probable or confirmed case* ContCaseID

Underlying conditions (tick all that apply)*

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

- Cardiovascular disease, including hypertension CVD Immunodeficiency, including HIV ImmunoDef

- Diabetes Diabetes Renal failure RenalFailure

- Liver disease LiverDis Chronic lung disease ChronLung

- Chronic neurological or neuromuscular disease Neurological Malignancy Malignancy

- Other underlying condition, specify OthUndCond

Other risk factors for disease* RiskSpec

Protective Factors

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

If yes, specify date of last vaccination* DtSeasVacc

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

If yes, specify date of last vaccination* DtPrePVacc

Management**CASE MANAGEMENT**

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

If yes, isolation start date* **IsolStartDt** Isolation end date* **IsolEndDate**

ANTI-VIRAL STATUS

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

If yes, provide additional details below:

Purpose of antiviral administration* (tick all that apply)

Post-exposure prophylaxis **PostExpP** Treatment **Treatment**

Medication*

Oseltamivir phosphate (Tamiflu®)* **Oseltamivir**

Date Started

DtOseltamivir

Baloxavir (Xofluza @)* **Baloxavir**

BaloxavirDt

Other, specify* **OthAntV**

OthAntVDt

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

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

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

Does not meet case definition **ReasNotCase** Outside treatment window **ReasTmtWndw** Person refused **ReasRefused** Unknown **ReasUnknown**

Other (specify) **ReasOthSpec**
ReasOther

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*	HHNumId <input type="text"/>	HHNumCoun <input type="text"/>	HHNumSym <input type="text"/>	HHNumProph <input type="text"/>
Healthcare setting / laboratory staff*	HCNumId <input type="text"/>	HCNumCoun <input type="text"/>	HCNumSym <input type="text"/>	HCNumProph <input type="text"/>
Other high risk close contact*	OthNumId <input type="text"/>	OthNumCoun <input type="text"/>	OthNumSym <input type="text"/>	OthNumProph <input type="text"/>

Comments*