TEXAS Department of State Health Services

Infectious Disease Control Unit, P.O. Box 149347, MC 1960, Austin, Texas 78714-149347
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Novel H1N1 Influenza Case Investigation Form

Final Status
☐ CONFIRMED ☐ RULED OUT/DROPPED **NBS PATIENT ID#**_____

Patient's Name:
_____
Last **First**
Address: _____
City: _____ **County:** _____ **Zip:** _____
Phone:( ) _____
Date of Birth: ___/___/___ **Age:** ____ **Sex:** ☐ Male ☐ Female ☐ Unknown
Race: ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Native American ☐ Unknown ☐ Other: _____ **Hispanic:** ☐ Yes ☐ No ☐ Unknown

Reported By: _____
Agency: _____
Phone:( )_____Date Reported: ___/___/___
Investigated by: _____
Agency: _____
Phone: ( ) _____Fax: ( )_____
Investigation Start Date: ____/____/____

Is the patient a Health Care Worker (HCW)? ☐ Yes ☐ No ☐ Unknown
If HCW, type of work:_____ If HCW, Place of work:_____

CLINICAL DATA:
Date of Symptom Onset: ___/___/___ Date of Death: ___/___/___
Weight: _____lbs Height: ____ft ____in

Signs and Symptoms (Check all that apply): ☐ Runny nose/nasal congestion
☐ Cough ☐ Conjunctivitis ☐ Diarrhea ☐ Headache ☐ Muscle aches
☐ Feverishness (measured or not) ☐ Fever greater than 37.8ºC (100ºF)
Max Temp _____ Date: _____/_____/_____
☐ Seizures ☐ Shortness of breath ☐ Sore throat ☐ Vomiting
☐ Other (Specify _____)
☐ Pregnant If pregnant, pre-pregnancy weight: _____ # weeks gestation: ____

UNDERLYING HEALTH CONDITIONS:
Please check all health conditions the patient has:
☐ None ☐ Asthma ☐ Chronic lung disease ☐ Cardiac disease
☐ COPD ☐ Diabetes Mellitus ☐ Hemoglobinopathy ☐ Kidney disease
☐ Seizures / Neuromuscular ☐ Other: _____
Does the patient have compromised immune function? ☐ Yes ☐ No
☐ Cancer in last 12 months ☐ HIV Infection
☐ Chronic corticosteroid therapy ☐ Organ transplant recipient
☐ Other: _____

VACCINATION HISTORY:
☐ Seasonal Flu 2009-2010 ☐ Yes ☐ No ☐ Unknown Date 1st vaccine ____/____/____ Date 2nd vaccine ____/____/____ ☐ Date Unknown
☐ Novel H1N1 2009 ☐ Yes ☐ No ☐ Unknown Date 1st vaccine ____/____/____ Date 2nd vaccine ____/____/____ ☐ Date Unknown
☐ Pneumococcal ☐ Yes ☐ No ☐ Unknown Date 1st vaccine ____/____/____ ☐ Date Unknown

TREATMENT:
Did the patient receive antiviral medication? ☐ Yes, start date _____/_____/_____ ☐ No ☐ Unknown
If yes, check all that apply: ☐ Oseltamivir ☐ Zanamivir ☐ Rimantidine ☐ Amantadine

HOSPITAL INFORMATION:
Was the patient hospitalized? ☐ Yes Name and location of hospital: _____ ☐ No
Date of admission: ____/____/____ Reason for Admission: ☐ Asthma Exacerbation ☐ Dehydration ☐ Pneumonia ☐ Respiratory Distress ☐ Other: _____
Was the patient admitted to the intensive care unit? ☐ Yes Admitted Date: ____/_____/____ ☐ No ☐ Unknown
Did the patient require mechanical ventilation? ☐ Yes ☐ No ☐ Unknown Required BiPAP: ☐ Yes ☐ No
Did the patient have evidence of secondary bacterial infection? ☐ Yes, culture result (organism): _____: ☐ No
Specimen Source (Blood, BAL, Sputum, other): _____ Date: _____/ _____/ _____

LABORATORY DATA: Was laboratory testing done? ☐ Yes ☐ No ☐ Unknown

PCR Test: Date collected: ____/____/____ Laboratory Name: _____Specimen#:_____
Specimen Source: ☐ Nasal swab ☐ NP swab ☐ NP aspirate ☐ Throat swab ☐ Dual NP/throat swab
Result: ☐ Influenza A, novel H1N1 ☐ Influenza A, seasonal strain ☐ Influenza A, subtyping not performed ☐ Influenza B ☐ Negative ☐ Inconclusive ☐ Not done

Viral Culture Result: Date collected: ____/____/____ Laboratory Name: _____Specimen#:_____
Specimen Source: ☐ Nasal swab ☐ NP swab ☐ NP aspirate ☐ Throat swab ☐ Dual NP/throat swab
Result: ☐ Influenza A, novel H1N1 ☐ Influenza A, seasonal strain ☐ Influenza A, subtyping not performed ☐ Influenza B ☐ Negative ☐ Inconclusive ☐ Not done