New Jersey Department of Health

AVIAN INFLUENZA SCREENING INFORMATION

Instructions: Fax completed form to: ________________

REPORTING INFORMATION

E-#: ___________________________  Reported By: ________________
CDRSS #: ______________________  Name: ______________________
PHEL Specimen#: __________________ Agency: __________________
Contact Number: __________________

PATIENT INFORMATION

Last Name: ______________________ First: ______________________
Address: ______________________
City: ___________________________ State: ______________________
County: _______________________ Municipality: ________________
Date of Birth: __/__/____  Age: ______  Gender: [ ] Male  [ ] Female
Occupation: ______________________

CLINICAL INFORMATION

Was the patient evaluated by a healthcare provider?
[ ] Yes  [ ] No  [ ] Unknown  If Yes, provide the following information:
Provider Name: __________________________  Address: __________________________
City: __________________________  State: __________________________
Primary Phone No.: __________________________  Secondary Phone No.: ________________

During the course of illness, was patient hospitalized?
[ ] Yes  [ ] No  [ ] Unknown
If Yes, Name of Hospital: __________________________
Was patient in ICU?  [ ] Yes  [ ] No  [ ] Unknown
Was the patient intubated?  [ ] Yes  [ ] No  [ ] Unknown

SIGNS AND SYMPTOMS

YES  NO  UNKNOWN
[ ] [ ] [ ] Fever >100.4°F (>38°C)
Onset Date: __/__/____
[ ] [ ] [ ] Were fever reducing drugs taken prior to temperature reading?
[ ] [ ] [ ] Feverish (temperature not taken)
[ ] [ ] [ ] Cough
[ ] [ ] [ ] Sore throat
[ ] [ ] [ ] Shortness of breath
[ ] [ ] [ ] Conjunctivitis

CLINICAL FINDINGS

YES  NO  UNKNOWN
[ ] [ ] [ ] Radiographically confirmed pneumonia
[ ] [ ] [ ] Acute respiratory distress syndrome (ARDS)
[ ] [ ] [ ] Other Illness (please describe):

LABORATORY TESTING

Was Rapid Antigen Test performed for influenza?
[ ] Yes  [ ] No  [ ] Unknown  If Yes, date specimen collected: __/__/____
Result: [ ] Influenza A  [ ] Influenza B  [ ] Influenza (type not specified)  [ ] Negative  [ ] Pending

RISK FACTORS

In 10 days prior to symptom onset:

YES  NO  UNKNOWN
[ ] [ ] [ ] Did patient travel to a country with documented animal or human cases of Avian Influenza*?
[ ] [ ] [ ] Did patient have direct contact with domestic poultry (e.g., touching sick or dead chickens or ducks or well appearing ducks)?
[ ] [ ] [ ] Did patient consume uncooked poultry or poultry products?
[ ] [ ] [ ] Did patient have direct contact with surfaces contaminated with poultry feces?
[ ] [ ] [ ] Did patient have close contact (within 3 feet) of a known or suspected human case of H5N1?

*http://www.cdc.gov/flu/avian/outbreaks/current.htm