Novel Influenza Worksheet

Send completed worksheet via mail to cdsfluteam@doh.nj.gov or fax to 609-292-5811.

Reporting Information

Reported By:

Name: _____ Contact Number: _____

Agency: _____ Report Date: ___/___/___ Contact email: _____

Patient Information

Name (Last, First, M.I.)	**Date of Birth (MM/DD/ YYYY)**	**Age**	**Sex**
	/ /		❑ Male ❑ Female

Race

❑ White ❑ Black/African American ❑ Asian ❑ American Indian/Alaska
❑ Native Hawaiian/Pacific Islander ❑ Unknown ❑ Other _____

Ethnicity

❑ Hispanic or Latino
❑ Not Hispanic or Latino
❑ Unknown

Address (Number, Street, Apt #, County, City, State, Zip Code)

Telephone

Home #: _____

Cell #: _____

Occupation

Clinical Information, Testing, Outcome, and Risk Factors

Onset Date of First Symptom: _____/_____/_____ **Onset Date of Fever, if Present:** _____/_____/_____

During this illness, did the patient experience any of the following symptoms?

Yes	No	Unknown		Yes	No	Unknown	
❑	❑	❑	Fever (highest temp _____ °F)	❑	❑	❑	Eye Infection/Redness
❑	❑	❑	Were fever reducing drugs taken prior to temperature reading?	❑	❑	❑	Muscle Aches
❑	❑	❑	Feverish (temperature not documented)	❑	❑	❑	Vomiting
❑	❑	❑	Sore Throat	❑	❑	❑	Diarrhea
❑	❑	❑	Rhinorrhea	❑	❑	❑	Rash
❑	❑	❑	Cough	❑	❑	❑	Fatigue
❑	❑	❑	Shortness of breath	❑	❑	❑	Seizures
❑	❑	❑	Headache	❑	❑	❑	Other, specify:
❑	❑	❑	Arthralgia				_____

Was the patient evaluated by a healthcare provider? ❑ Yes ❑ No ❑ Unknown If yes, provide the following information:

Provider Name: _____ Date of Visit: _____/_____/_____

Address: _____ City: _____ State: _____ Zip Code: _____

Primary Phone #: _____ Provider Email: _____

During the course of illness, was the patient hospitalized? ❑ Yes ❑ No ❑ Unknown If yes, provide the following information:

Hospital Name: _____

Date of Admission: _____/_____/_____ Date of Discharge: _____/_____/_____

Was the patient in ICU? ❑ Yes ❑ No ❑ Unknown If yes, Date of Admission: _____/_____/_____

Fatality? ❑ Yes ❑ No ❑ Unknown If yes, Date of Death: _____/_____/_____

In the 10 days prior to illness onset, did the patient travel outside of his/her usual area? ❑ Yes ❑ No ❑ Unknown

1. When and where did the patient travel? **Please describe details of the patient's travel in the notes section at the end of the form.**
   Trip 1: Dates of travel:____/____/____to____/____/____Country_____State_____City/County_____
   Trip 2: Dates of travel:____/____/____to____/____/____Country_____State_____City/County_____
2. Did the patient travel in a group (check all that apply)?
   ❑ No, traveled alone ❑ Yes, with household members ❑ Yes, with non-household members ❑ Unknown
3. Please describe the details of the trip _____

In the 10 days before becoming ill, did the patient drink any raw or unpasteurized milk from a cow or other animal sources, including drinking milk on the farm where it was produced or drinking milk from the "bulk tank"?

❑ Yes ❑ No ❑ Unknown ❑ Refused

(If *yes* ask sub-questions *a* through *g,* write in "Refused" if refused to answer or "NA" if question not applicable)

a) What type of milk (cow milk, goat milk, etc.), variety, and brand: _____ ❑ Unknown
b) What was the first date of consumption in the 10 days before becoming ill (MM-DD-YYY): _____ ❑ Unknown
c) Where was the milk acquired (store name, farm name, herd share, etc.): _____ ❑ Unknown
d) What was the address, city, and state of acquisition (if not case's home):_____ ❑ Unknown
e) What was the product expiration/best by/best before date: _____ ❑ Unknown
f) What was the product lot number or code on the packaging:_____ ❑ Unknown
g) Is there any remaining product? ❑ Yes ❑ No ❑Unknown

In the 10 days before becoming ill, did the patient consume any raw or unpasteurized milk products? (select all that apply):

❑ Raw milk cheese ❑ Heavy raw cream ❑Whole raw kefir ❑ Raw butter ❑ Raw yogurt
❑ Raw kefir pet food ❑ Raw milk pet food ❑Other (specify): _____
❑ Unknown ❑ Refused

(If *yes* ask sub-questions *h* through *n,* write in "Refused" if refused to answer or "NA" if question not applicable)

h) What was the type (cow milk, goat milk, etc.), variety, and brand: _____ ❑ Unknown
i) What was the consumption date (MM-DD-YYY): _____ ❑ Unknown
j) Where was the milk product acquired (store name, farm name, herd share, etc.): _____ ❑ Unknown
k) What was the address, city, and state of acquisition (if not case's home):_____ ❑ Unknown
l) What was the product expiration/best by/best before date: _____ ❑ Unknown
m) What was the product lot number or code on the packaging:_____ ❑ Unknown
n) Is there any remaining product? ❑Yes ❑No ❑Unknown

Yes	No	Unknown	
❑	❑	❑	Does the patient handle samples (animal or human) suspected of containing influenza virus in a laboratory or other setting?
❑	❑	❑	In the 7 days before or after becoming ill, did the patient attend or work at a childcare facility? If yes, specify role: _____
❑	❑	❑	Did the patient work in or volunteer at a healthcare facility or setting? If yes, specify role: _____
❑	❑	❑	Does the patient live in an institutional or group setting? If yes, specify: _____
❑	❑	❑	Does the patient know anyone who had respiratory symptoms in the 7 days BEFORE the case patient's illness onset?

Was testing performed for Influenza? ❑ Yes ❑ No ❑ Unknown If yes, provide the following information:

Yes	No	Unknown			
❑	❑	❑	PCR?	Collection date: _____/_____/_____	Result/Typing: _____
❑	❑	❑	Rapid Antigen?	Collection date: _____/_____/_____	Result/Typing: _____
❑	❑	❑	Culture?	Collection date: _____/_____/_____	Result/Typing: _____

Were any of the following clinical findings present?

Yes	No	Unknown		
❑	❑	❑	Radiographically confirmed pneumonia	If yes, date: _____/_____/_____
❑	❑	❑	Acute respiratory distress syndrome (ARDS)	
❑	❑	❑	Other severe respiratory illness for which an alternative diagnosis has not been established	
❑	❑	❑	Other (please describe):	

_____

_____

Did the patient receive influenza antiviral medications prior to becoming ill (within 2 weeks) or after becoming ill?

❑ **Yes, (please complete table below)** ❑ **No** ❑ **Unknown**

Drug	Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)	Total number of days receiving antivirals	Dosage (if known)
Oseltamivir (Tamiflu)				mg
Zanamivir (Relenza)				mg
Peramivir (Rapivab)				mg
Other influenza antiviral:				mg

Exposure History

Did the patient have any of the following potential exposures listed below <u>within 10 days</u> of symptoms onset? (check all that apply)

Yes	No	Unknown	
❑	❑	❑	Close contact (within 6 feet) with a confirmed human case of novel influenza A virus infection
❑	❑	❑	Shared a common exposure (such as an agricultural fair or live animal market) with a confirmed novel influenza A case
❑	❑	❑	Direct or indirect contact (such as touching an animal, their environment, or their raw or unprocessed animal products) with animals with confirmed influenza A
❑	❑	❑	Inadequate use or breach of PPE and exposed to novel influenza A virus in a laboratory
❑	❑	❑	Contact with animals from any of the following categories: ❑ Domestic poultry (e.g., chicken, turkey, ducks) ❑ Wild aquatic birds, (e.g., ducks, geese, swans) ❑ Captive birds of prey (e.g., falcons) that have contact with wild aquatic birds ❑Sheep ❑Goats ❑Horses ❑Cows ❑Pigs/Hogs ❑Other (Specify) _____

If yes to any of the above, where did the exposure occur? ❑Home ❑Work ❑Agricultural Fair ❑Live Animal Market ❑Petting Zoo ❑Other (Specify) _____

Provide address for where exposure occurred:_____

Additional Notes

Additional Information available at: https://www.nj.gov/health/cd/topics/novel_flu.shtml