

CASE REPORT FORM

Avian Influenza

	EpiSurv No.
--	--

Reporting Authority			
Name of Public Health Officer responsible for case OfficerName			
Notifier Identification (i)			
Reporting source* <input type="radio"/> General Practitioner <input type="radio"/> Hospital-based Practitioner <input type="radio"/> Laboratory Report Src <input type="radio"/> Self-notification <input type="radio"/> Outbreak Investigation <input type="radio"/> Other			
Name of reporting source ReportName		Organisation ReportOrganisation	
Date reported* ReportDate	Laboratory sample date SampleDate	Contact phone ReportPhone	
Usual GP UsualGP	Practice GPPracticeName	GP phone GPPhone	
GP/Practice address Number houzenumber Street streetname Suburb suburb GpAddress Town/City towncity Post Code postcode <input type="checkbox"/> GeoCode 			
Case Identification (i)			
Name of case* Surname Surname		Given Name(s) GivenName	
NHI number* NHINumber	Email Email		
Current address* Number Street Suburb CaseAddress Town/City Post Code <input type="checkbox"/> GeoCode 			
Phone (home) PhoneHome	Phone (work) PhoneWork	Phone (other) PhoneOther	
Case Demography			
Location TA* TA		DHB* DHB	
Date of birth* DateOfBirth OR Age Age AgeUnits <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years Sex* Sex <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown <input type="radio"/> Other			
Occupation* Occupation (i)			
Occupation location Occupation_place_type - main <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school			
Name occupation_place_name - main			
Address Number Street Suburb PlaceOfWork - Main Town/City Post Code <input type="checkbox"/> GeoCode 			
Alternative location Occupation_place_type - Alternative <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school			
Name occupation_place_name - Alternative			
Address Number Street Suburb PlaceOfWork - Alternative Town/City Post Code <input type="checkbox"/> GeoCode 			
Ethnic group case belongs to* (tick all that apply) (i)			
<input type="checkbox"/> NZ European EthNZEuroean <input type="checkbox"/> Maori EthMaori <input type="checkbox"/> Samoan EthSamoan <input type="checkbox"/> Cook Island Maori EthCookIslandMaori <input type="checkbox"/> Niuean EthNiuean <input type="checkbox"/> Chinese EthChinese <input type="checkbox"/> Indian EthIndian <input type="checkbox"/> Tongan EthTongan <input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan) EthOther *(specify) EthSpecify1 EthSpecify2			

DiseaseName	EpiSurv No. EpiSurvNumber
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 <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Was the case asymptomatic?* Asymptomatic <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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"/> General weakness Weakness	<input type="checkbox"/> Headache Headache
<input type="checkbox"/> Nausea/vomiting NausVom	<input type="checkbox"/> Abdominal pain PainAbdom
<input type="checkbox"/> Sore throat SoreThroat	<input type="checkbox"/> Muscular pain PainMusc
<input type="checkbox"/> Runny nose RunNose	<input type="checkbox"/> Chest pain PainChest
<input type="checkbox"/> Shortness of breath ShBreath	<input type="checkbox"/> Joint pain PainJoint
<input type="checkbox"/> Irritability/confusion IritConfus	<input type="checkbox"/> Conjunctivitis Conjunctvts
<input type="checkbox"/> Other symptoms, specify* OthSymptoms OthSymSpec <input style="width: 150px;" 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	
LABORATORY CRITERIA (i)	
Laboratory confirmation of avian influenza* LabConf <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results	
If yes, specify laboratory confirmation method (tick all that apply)*	
Positive PCR test for influenza A PCRFluA <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results	
If yes, subtyping result FluASubtype <input type="radio"/> H5 <input type="radio"/> H7 <input type="radio"/> H9 <input type="radio"/> Not Done <input type="radio"/> Awaiting Results	
Four-fold or greater rise in HPAI virus-specific neutralising antibodies* Titre4x <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results	
Whole genome sequencing characterisation avian influenza* WGSScham <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting results	
Other positive test (specify*) OthPosSpec <input style="width: 150px;" type="text"/>	
EPIDEMIOLOGICAL CRITERIA (i)	
Fits epidemiological criteria?* FitsEpi <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
CLASSIFICATION* Status <input type="radio"/> Under investigation <input type="radio"/> Probable <input type="radio"/> Confirmed <input type="radio"/> Not a case (i)	
ADDITIONAL LABORATORY DETAILS	
Organism subtype (eg H and N type/clade)* AddLab <input style="width: 150px;" type="text"/>	
Clinical Course and Outcome	
Date of onset* OnsetDt <input style="width: 100px;" type="text"/> <input type="checkbox"/> Approximate OnsetDtApprox <input type="checkbox"/> Unknown OnsetDtUnknown	
Hospitalised* Hosp <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Date hospitalised* HospDt <input style="width: 100px;" type="text"/> <input type="checkbox"/> Unknown HospDtUnknown	
Hospital* HospName <input style="width: 150px;" type="text"/>	
Died* Died <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Date died* DiedDt <input style="width: 100px;" type="text"/> <input type="checkbox"/> Unknown DiedDtUnknown	
Was this disease the primary cause of death?* DiedPrimary <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
If no, specify the primary cause of death* DiedOther <input style="width: 150px;" type="text"/>	

DiseaseName	EpiSurv No. EpiSurvNumber
Additional Outcome Details	
Was the case in ICU?* ICU	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Ventilation required* VentReqd	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Extracorporeal membrane oxygenation required (ECMO)* ECMO	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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 <input type="checkbox"/> Yes If yes, specify Outbreak No.* OutbrkNo	
Risk Factors	
Was the case overseas during the incubation period for this disease?* Overseas	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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.	
<input type="checkbox"/> Human healthcare work HumHCare <input type="checkbox"/> Animal healthcare work AnimHCare <input type="checkbox"/> Health laboratory work HumHLab <input type="checkbox"/> Animal health laboratory work AnimHLab	
If undertaking laboratory work, are avian influenza virus samples handled there? AvInfLab	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
<input type="checkbox"/> Work or recreation with wild or domestic animals (tick all that apply) ExpAnimals	
<input type="checkbox"/> Wild birds WildBirds <input type="checkbox"/> Commercial poultry ComPoultry <input type="checkbox"/> Domestic birds DomBirds <input type="checkbox"/> Cats Cats <input type="checkbox"/> Other domestic pets OtherPets	
<input type="checkbox"/> Cattle Cattle <input type="checkbox"/> Marine animals MarineAn <input type="checkbox"/> Other animal OtherAn specify OtherAnSpec	
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	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
If yes, EpiSurv number of probable or confirmed case* ContCaseID	
Underlying conditions (tick all that apply)*	
<input type="checkbox"/> Pregnancy Pregnancy If yes, trimester Trimester <input type="checkbox"/> Post-partum (< 6 weeks) PostPartum	
<input type="checkbox"/> Cardiovascular disease, including hypertension CVD <input type="checkbox"/> Immunodeficiency, including HIV ImmunoDef	
<input type="checkbox"/> Diabetes Diabetes <input type="checkbox"/> Renal failure RenalFailure	
<input type="checkbox"/> Liver disease LiverDis <input type="checkbox"/> Chronic lung disease ChronLung	
<input type="checkbox"/> Chronic neurological or neuromuscular disease Neurological <input type="checkbox"/> Malignancy Malignancy	
<input type="checkbox"/> Other underlying condition OthUndCond specify OthCondSpec	
Other risk factors for disease* RiskSpec	
Protective Factors	
Has the case had a seasonal influenza vaccination in the last 12 months?* SeasVacc	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
If yes, specify date of last vaccination* DtSeasVacc	
Has the case had pre-pandemic influenza vaccination in the last 12 months?* PrePVacc	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
If yes, specify date of last vaccination* DtPrePVacc	

DiseaseName	EpiSurv No. EpiSurvNumber																
Management																	
CASE MANAGEMENT																	
Was the case advised to isolate for an appropriate period?* Isolation <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown 																	
If yes, isolation start date* IsolStartDt <input style="width: 150px;" type="text"/> Isolation end date* IsolEndDt <input style="width: 150px;" type="text"/>																	
ANTI-VIRAL STATUS																	
Did the case receive antivirals?* AntiVTmt <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown 																	
If yes, provide additional details below: Purpose of antiviral administration* (tick all that apply)																	
<div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> Post-exposure prophylaxis PostExpP <input type="checkbox"/> Treatment Treatment </div>																	
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; width: 60%;">Medication*</th> <th style="text-align: left; width: 40%;">Date Started</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Oseltamivir phosphate (Tamiflu®)* Oseltamivir</td> <td>DtOseltamivir <input style="width: 100px;" type="text"/></td> </tr> <tr> <td><input type="checkbox"/> Baloxavir (Xofluza ®)* Baloxavir</td> <td>BaloxavirDt <input style="width: 100px;" type="text"/></td> </tr> <tr> <td><input type="checkbox"/> Other, specify* OtherAntiV OthAntiVSpec <input style="width: 100px;" type="text"/></td> <td>OthAntiVDt <input style="width: 100px;" type="text"/></td> </tr> </tbody> </table>		Medication*	Date Started	<input type="checkbox"/> Oseltamivir phosphate (Tamiflu®)* Oseltamivir	DtOseltamivir <input style="width: 100px;" type="text"/>	<input type="checkbox"/> Baloxavir (Xofluza ®)* Baloxavir	BaloxavirDt <input style="width: 100px;" type="text"/>	<input type="checkbox"/> Other, specify* OtherAntiV OthAntiVSpec <input style="width: 100px;" type="text"/>	OthAntiVDt <input style="width: 100px;" type="text"/>								
Medication*	Date Started																
<input type="checkbox"/> Oseltamivir phosphate (Tamiflu®)* Oseltamivir	DtOseltamivir <input style="width: 100px;" type="text"/>																
<input type="checkbox"/> Baloxavir (Xofluza ®)* Baloxavir	BaloxavirDt <input style="width: 100px;" type="text"/>																
<input type="checkbox"/> Other, specify* OtherAntiV OthAntiVSpec <input style="width: 100px;" type="text"/>	OthAntiVDt <input style="width: 100px;" type="text"/>																
Was the prescribed dose of antiviral medication taken every day prior to illness?* AntiVEvDay <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown 																	
If antivirals have not been received, are they planned?* AVPlanned <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown 																	
If antiviral treatment was considered but not given, specify reason* (tick all that apply)																	
<div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> Does not meet case definition ReasNotCase <input type="checkbox"/> Outside treatment window ReasTmtWndw <input type="checkbox"/> Person refused ReasRefused <input type="checkbox"/> Unknown ReasUnknown </div>																	
<input type="checkbox"/> Other (specify) ReasOther ReasOthSpec <input style="width: 200px;" type="text"/>																	
CONTACT MANAGEMENT																	
Please summarise all high risk contacts of the case																	
Contact Type*	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Number identified</th> <th style="width: 20%;">Number counselled</th> <th style="width: 20%;">Number with symptoms</th> <th style="width: 40%;">Number given post exposure prophylaxis</th> </tr> </thead> <tbody> <tr> <td>Household* HHNumID <input style="width: 50px;" type="text"/></td> <td>HHNumCoun <input style="width: 50px;" type="text"/></td> <td>HHNumSym <input style="width: 50px;" type="text"/></td> <td>HHNumProph <input style="width: 50px;" type="text"/></td> </tr> <tr> <td>Healthcare setting / laboratory staff* HCNumID <input style="width: 50px;" type="text"/></td> <td>HCNumCoun <input style="width: 50px;" type="text"/></td> <td>HCNumSym <input style="width: 50px;" type="text"/></td> <td>HCNumProph <input style="width: 50px;" type="text"/></td> </tr> <tr> <td>Other high risk close contact* OthNumID <input style="width: 50px;" type="text"/></td> <td>OthNumCoun <input style="width: 50px;" type="text"/></td> <td>OthNumSym <input style="width: 50px;" type="text"/></td> <td>OthNumProph <input style="width: 50px;" type="text"/></td> </tr> </tbody> </table>	Number identified	Number counselled	Number with symptoms	Number given post exposure prophylaxis	Household* HHNumID <input style="width: 50px;" type="text"/>	HHNumCoun <input style="width: 50px;" type="text"/>	HHNumSym <input style="width: 50px;" type="text"/>	HHNumProph <input style="width: 50px;" type="text"/>	Healthcare setting / laboratory staff* HCNumID <input style="width: 50px;" type="text"/>	HCNumCoun <input style="width: 50px;" type="text"/>	HCNumSym <input style="width: 50px;" type="text"/>	HCNumProph <input style="width: 50px;" type="text"/>	Other high risk close contact* OthNumID <input style="width: 50px;" type="text"/>	OthNumCoun <input style="width: 50px;" type="text"/>	OthNumSym <input style="width: 50px;" type="text"/>	OthNumProph <input style="width: 50px;" type="text"/>
Number identified	Number counselled	Number with symptoms	Number given post exposure prophylaxis														
Household* HHNumID <input style="width: 50px;" type="text"/>	HHNumCoun <input style="width: 50px;" type="text"/>	HHNumSym <input style="width: 50px;" type="text"/>	HHNumProph <input style="width: 50px;" type="text"/>														
Healthcare setting / laboratory staff* HCNumID <input style="width: 50px;" type="text"/>	HCNumCoun <input style="width: 50px;" type="text"/>	HCNumSym <input style="width: 50px;" type="text"/>	HCNumProph <input style="width: 50px;" type="text"/>														
Other high risk close contact* OthNumID <input style="width: 50px;" type="text"/>	OthNumCoun <input style="width: 50px;" type="text"/>	OthNumSym <input style="width: 50px;" type="text"/>	OthNumProph <input style="width: 50px;" type="text"/>														
Comments*																	
Comments <div style="border: 1px solid black; height: 200px; margin-top: 5px;"></div>																	