**Influenza, Novel**

<table>
<thead>
<tr>
<th>ADMINISTRATIVE</th>
<th>DEMOGRAPHICS</th>
</tr>
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<tbody>
<tr>
<td>Investigator</td>
<td>Age at symptom onset</td>
</tr>
<tr>
<td>LHJ Case ID (optional)</td>
<td>Hispanic or Latino</td>
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<tr>
<td>LHJ notification date</td>
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<td>Classification</td>
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<td>Native Hl/other PI</td>
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<td>Probable</td>
<td>Other</td>
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<tr>
<td>Ruled out</td>
<td>Other</td>
</tr>
<tr>
<td>Suspect</td>
<td>Other</td>
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</tbody>
</table>

**Investigation status**
- In progress
- Complete
- Complete – not reportable to DOH
- Unable to complete
- Reason

**Investigation start date**

**Investigation complete date**

**Case complete date**

**Outbreak related**
- Yes
- No

**LHJ Cluster ID**

**Cluster Name**

**REPORT SOURCE**

<table>
<thead>
<tr>
<th>COMMUNICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial report source</td>
</tr>
<tr>
<td>LHJ</td>
</tr>
<tr>
<td>Reporter organization</td>
</tr>
<tr>
<td>Reporter name</td>
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<tr>
<td>Reporter phone</td>
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</table>

**All reporting sources (list all that apply)**

**CLINICAL INFORMATION**

<table>
<thead>
<tr>
<th>Clinical Features</th>
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<tbody>
<tr>
<td>Y</td>
</tr>
<tr>
<td>Any fever, subjective or measured</td>
</tr>
<tr>
<td>Cough</td>
</tr>
<tr>
<td>Onset date</td>
</tr>
<tr>
<td>Croup</td>
</tr>
<tr>
<td>Diarrhea (3 or more loose stools within a 24 hour period)</td>
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<tr>
<td>Dyspnea (shortness of breath)</td>
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<tr>
<td>Fatigue</td>
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<tr>
<td>Malaise</td>
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<tr>
<td>Headache</td>
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<tr>
<td>Myalgia (muscle aches or pain)</td>
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<tr>
<td>Nausea</td>
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<tr>
<td>Vomiting</td>
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</table>

*Novel Influenza required variables are in bold. Answers are: Yes, No, Unknown to case*
### Novel Influenza

**Y** ☐ Seizure new with disease

**Y** ☐ Pharyngitis (sore throat)

**Y** ☐ Pneumonia  
Diagnosed by ☐ X-Ray  ☐ CT  ☐ MRI  ☐ Provider Only

**Y** ☐ Result ☐ Positive  ☐ Negative  ☐ Indeterminate  ☐ Not tested  ☐ Other

**Y** ☐ Rash

**Y** ☐ Other symptoms consistent with this illness

**Y** ☐ Acute respiratory distress syndrome (ARDS)

**Y** ☐ Any other complication

Chest X-ray or CAT scan results ☐ Normal  ☐ Detected new abnormality  ☐ Not performed  ☐ Unk

---

### Pediatric Death Only

**Y** ☐ Bronchiolitis

**Y** ☐ Encephalitis or encephalomyelitis

**Y** ☐ Hemorrhagic pneumonia/pneumonitis

**Y** ☐ Myocarditis

**Y** ☐ Cerebral palsy

**Y** ☐ Reye syndrome

**Y** ☐ Shock

**Y** ☐ Neurologic/neurodevelopmental disorder

**Y** ☐ Moderate to severe developmental delay

**Y** ☐ Sepsis syndrome

**Y** ☐ Another viral co-infection

**Y** ☐ Did cardiac/respiratory arrest occur outside the hospital

---

### Predisposing Conditions

**Y** ☐ Alcohol or drug abuse

**Y** ☐ Asthma/reactive airway disease

**Y** ☐ Cancer chemotherapy in past 12 months

**Y** ☐ Chronic heart disease

**Y** ☐ Chronic lung disease (e.g., COPD, emphysema)

**Y** ☐ Connective tissue disorder

**Y** ☐ Current tobacco smoker

**Y** ☐ Diabetes mellitus

**Y** ☐ Anemia

**Y** ☐ Hemoglobinopathy (e.g., sickle cell disease)

**Y** ☐ HIV positive/AIDS

**Y** ☐ Non-cancer immunosuppressive condition

**Y** ☐ Steroid therapy

**Y** ☐ Liver disease

**Y** ☐ Obesity  
Height (in inches) _______  
Weight (in pounds) _______

**Y** ☐ Organ transplant

**Y** ☐ Other underlying medical conditions

**Y** ☐ Frequently use a stroller or wheelchair  
Describe ______________________________________

---

### Pediatric Death Only

**Y** ☐ Cystic fibrosis

**Y** ☐ History of febrile seizures

**Y** ☐ Cancer diagnosis or treatment in 12 months prior to onset

**Y** ☐ Chromosomal abnormality/genetic syndrome

**Y** ☐ Chronic kidney disease

**Y** ☐ Immunosuppressive therapy before illness onset

**Y** ☐ Neuromuscular disorder (e.g., muscular dystrophy)

**Y** ☐ History of seizures

**Y** ☐ Mitochondrial disorder

**Y** ☐ Premature at birth  
Gestation age _____ weeks

**Y** ☐ Skin or soft tissue infection (SSTI)

**Y** ☐ Endocrine disorder

---

### Pregnancy

Pregnancy status at time of symptom onset

☐ Pregnant  
(Estimated) delivery date ___/___/___  
Weeks pregnant at any symptom onset _______

OB name, phone, address ______________________________________

Outcome of pregnancy ☐ Still pregnant  ☐ Fetal death (miscarriage or stillbirth)  ☐ Abortion

☐ Delivered – full term  ☐ Delivered – preemie  ☐ Delivered – Unk

Delivery method ☐ Vaginal  ☐ C-section  ☐ Unk

☐ Postpartum  
(Estimated) delivery date ___/___/___

OB name, phone, address ______________________________________
### Vaccination

#### Y N Unk
- **Vaccinated against influenza in the past year**
  - Yes
  - No
  - Unknown

#### Date of vaccine administration ___/___/___
- **Vaccine administered (Type) ___________________________________**
- **Vaccine lot number ________________________________**
- **Administering provider ________________________________**

### Pediatric Death Only

#### Y N Unk
- **Influenza vaccine in previous season**
  - Yes
  - No
  - Unknown

#### Received 2 doses of vaccine during a previous season (if patient was less than 8 years of age at the time of death)

### Clinical testing

#### Y N Unk
- **Leukopenia defined as total white blood cell count < 5,000/mm³**
- **Lymphopenia defined as total lymphocytes <800/mm³ or lymphocytes <15% of WBC**
- **Thrombocytopenia defined as platelets < 150,000 /mm³**

### Pediatric Death Only

#### Pathology specimens sent to CDCs Infectious Disease Pathology Branch  Lab ID _______________________________
- **Influenza isolates or original clinical material sent to CDCs Influenza Division  Lab ID _____________________________**
- **Were other respiratory specimens collected for bacterial culture (e.g., sputum, ET tube aspirate) Specify _________________________________**
- **Was a specimen collected for bacterial culture from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid? Specimens collected greater than 24 hours after death are not sterile**
  - **Specimen type**
    - Blood
    - Pleural fluid
    - Lung tissue
    - CSF
    - Unknown
    - Other _________________________________
  - **Collection date ___/___/___**
  - **Result**
    - Positive
    - Negative
    - Unknown

### Physician Reporting/Patient Healthcare

#### When did the patient feel back to normal ___/___/___
- **Y N Unk**
- **Did the patient receive any medical care for this illness**
  - Yes
  - No
  - Unknown

#### Where did the patient seek care
  - Doctor’s office
  - Hospital
  - Emergency room
  - Urgent care clinic
  - Health department
  - Unknown
  - Other _________________________________

#### Date seen ___/___/___
- **Y N Unk**
- **Hospitalized at least overnight for this illness**
  - Yes
  - No
  - Unknown

#### Facility name ________________________________
- **Hospital admission date ___/___/___**
- **Discharge ___/___/___**
- **HRN _____________________**
- **Admitted to ICU**
  - Yes
  - No
  - Unknown

#### Date admitted to ICU ___/___/___
- **Date discharged from ICU ___/___/___**
- **Mechanical ventilation or intubation required**
  - Yes
  - No
  - Unknown

#### Required for ________ days
- **Still hospitalized As of ___/___/___**
- **Where was the patient discharged**
  - Home
  - Nursing/rehab
  - Hospice
  - Unknown
  - Other _________________________________

#### Y N Unk
- **Died of this illness**
  - Yes
  - No
  - Unknown

#### Death date ___/___/___
- **Autopsy performed**
  - Yes
  - No
  - Unknown

#### Was a specimen (e.g., fixed lung tissue) collected from an autopsy for testing of bacterial pathogens by a local or state pathologist?
- **Death certificate lists disease as a cause of death or a significant contributing condition**
- **Health care visit prior to death**
  - Location of death
    - Outside of hospital (e.g., home or in transit to the hospital)
    - Emergency department (ED)
    - Inpatient ward
    - ICU
    - Other _________________________________
**RISK AND RESPONSE (Ask about exposures in the 7 days before symptom onset)**

**Travel**
- **Y** Yes
- **N** No
- **Unk** Unknown

- Did the patient travel in a group **No**
- **With household members**
- **With non-household members**

<table>
<thead>
<tr>
<th>Setting 1</th>
<th>Setting 2</th>
<th>Setting 3</th>
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</thead>
<tbody>
<tr>
<td>Travel out of:</td>
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<tr>
<td>County/City</td>
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<td>Country</td>
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<tr>
<td>Other</td>
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<tr>
<td>Destination name</td>
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<tr>
<td>Start and end dates</td>
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</tr>
</tbody>
</table>

**Risk and Exposure Information**
- **Y** Yes
- **N** No
- **Unk** Unknown

- Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor)
- **Country** __________________________

- Contact with person with pneumonia or influenza-like illness
- **Barracks**
- **Corrections**
- **Long term care**
- **Dormitory**
- **Boarding school**
- **Camp**
- **Shelter**

- (Potential) Occupational exposure

**In the 7 days before or after symptom onset**

**How many people resided in the patient’s household(s) ______**

A household member is anyone with at least one overnight stay +/- 7 days from patient’s illness onset, and the patient may have resided in >1 household. Please complete the table below for each household member and continue in the notes section if more space is needed.

<table>
<thead>
<tr>
<th>Row</th>
<th>Household (HH) ID</th>
<th>Relation to patient (e.g., parent, brother, friend)</th>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Fever or any respiratory symptoms +/- 7 days from case patient’s onset</th>
<th>Date of illness onset</th>
<th>If HH member ILL</th>
<th>Any pig/hog contact &lt;7 days before his/her onset</th>
<th>Attend agricultural fair &lt;7 days before his/her onset</th>
<th>If HH member NOT ILL</th>
<th>Any pig/hog contact or fair attendance &lt;10 days before patient’s onset</th>
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<tbody>
<tr>
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<td>1 2</td>
<td>1</td>
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<td>M</td>
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</tr>
</tbody>
</table>

**In the 7 days before or after symptom onset**

**Y** Yes

- Did the patient attend or work at a childcare facility
  - Approximately how many children are in the patient’s class or room at the childcare facility ______

- Did the patient attend or work at a school
  - Approximately how many students are in the patient’s class at the school ______

- Did anyone else in the patient’s household(s) work at or attend a childcare facility or school
  - List row number from table above for household members working at or attending a child care facility or school ______
In the 7 days before symptom onset
Y  N  Unk
☐ ☐ ☐ Did the patient attend an agricultural fair/event or live animal market
  Name(s) or fair(s) ____________________________
  On what days did the patient attend an agricultural fair/event or live animal market (select all that apply)
  ☐ On day of illness onset ☐ 1 day before ☐ 2 days before ☐ 3 days before ☐ 4 days before ☐ 5 days before
  ☐ 6 days before ☐ 7 days before
☐ ☐ ☐ Does anyone else in the household own, keep or care for livestock animals
  What type(s) or animals are kept or cared for by household members (check all that apply)
  ☐ Horse ☐ Cows ☐ Poultry/wild birds ☐ Sheep ☐ Goats ☐ Pig/hogs ☐ Other __________________________
☐ ☐ ☐ 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 symptom onset
☐ ☐ ☐ Did the patient have DIRECT contact with (touch or handle) any livestock animals like poultry or pigs
  What type(s) of animals did the patient have direct contact with
  ☐ Horse ☐ Cows ☐ Poultry/wild birds ☐ Sheep ☐ Goats ☐ Pig/hogs ☐ Other __________________________
  Where did the direct contact occur
  ☐ Home ☐ Work ☐ Agricultural fair or event ☐ Live animal market ☐ Petting zoo ☐ Other __________________________
☐ ☐ ☐ Did the patient have INDIRECT contact with (walk through an area containing or come within 6 feet of) any livestock animals
  What type(s) of animals did the patient have indirect contact with
  ☐ Horse ☐ Cows ☐ Poultry/wild birds ☐ Sheep ☐ Goats ☐ Pig/hogs ☐ Other __________________________
  Where did the indirect contact occur
  ☐ Home ☐ Work ☐ Agricultural fair or event ☐ Live animal market ☐ Petting zoo ☐ Other __________________________

If ANY contact with animals
☐ ☐ ☐ Did the patient have direct or indirect contact with any animal exhibiting signs of illness
  Animal type/location __________________________________
If ANY contact with pigs/hogs
On what days did the patient have ANY contact (direct, indirect or both) with pigs
  ☐ On day of illness onset ☐ 1 day before ☐ 2 days before ☐ 3 days before ☐ 4 days before ☐ 5 days before
  ☐ 6 days before ☐ 7 days before
What was the total number of different days the patient reported ANY pig contact (direct or indirect, or both)
  ☐ 1 day ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days ☐ 6 days ☐ 7 days

In the 7 days before or after symptom onset
Y  N  Unk
☐ ☐ ☐ Did the patient work or volunteer at a healthcare facility or setting
  Healthcare facility job/role ☐ Physician ☐ Nurse ☐ Administration staff ☐ Housekeeping ☐ Patient transport
  ☐ Volunteer ☐ Other __________________________
☐ ☐ ☐ Was the patient in a hospital for any reason (e.g., visiting, working, or for treatment)
  Earliest exposure date ___/___/___ Latest exposure date ___/___/___ City/town __________________________
☐ ☐ ☐ Was the patient in a clinic or doctor’s office for any reason
  Earliest exposure date ___/___/___ Latest exposure date ___/___/___ City/town __________________________
☐ ☐ ☐ Did the patient have close contact (e.g., caring for, speaking with, or touching) with anyone other than a household member who routinely has contact with pigs/hogs
☐ ☐ ☐ Does the patient know anyone other than a household member who had fever, respiratory symptoms like cough or sore throat, or another respiratory illness like pneumonia in the 7 days BEFORE the case patient’s illness onset?

<table>
<thead>
<tr>
<th>Relation to patient (e.g., parent, brother, friend)</th>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Date of illness onset</th>
<th>Any pig/hog contact or fair attendance ≤7 days before his/her onset</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
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Novel Influenza required variables are in **bold**. Answers are: Yes, No, Unknown to case
Does the patient know anyone other than a household member who had fever, respiratory symptoms like cough or sore throat, or another respiratory illness like pneumonia beginning AFTER the case patient’s illness onset

<table>
<thead>
<tr>
<th>Relation to patient (e.g., parent, brother, friend)</th>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Date of illness onset</th>
<th>Any pig/hog contact or fair attendance ≤ 7 days before his/her onset</th>
<th>Comments</th>
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Is the patient a contact of a confirmed or probable case of novel influenza A infection

<table>
<thead>
<tr>
<th>Relation to patient (e.g., parent, brother, friend)</th>
<th>Name</th>
<th>State Epi ID</th>
<th>State Lab ID</th>
<th>Case Status</th>
<th>Sex</th>
<th>Age</th>
<th>Date of illness onset</th>
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Additional comments/note (e.g., travel details, names/dates or fairs attended by case patient, dates of household member fair attendance and location of fair, information about other ill contacts)

- No risk factors or likely exposures could be identified

**Exposure and Transmission Summary**

- Epi-link to a confirmed or probable case of novel influenza
- Outbreak related

Likely geographic region of exposure

- In Washington – county _____________
- Other state ______________
- Not in US - country _____________
- Unk
International travel related [ ] During entire exposure period [ ] During part of exposure period [ ] No international travel

Suspected exposure type [ ] Foodborne [ ] Waterborne [ ] Animal related [ ] Vectorborne [ ] Person to person [ ] Sexual
[ ] Blood products [ ] IDU [ ] Healthcare Associated [ ] Unk [ ] Other _____________________________

Describe _____________________________

Suspected exposure setting [ ] Daycare/Childcare [ ] School (not college) [ ] Doctor’s office [ ] Hospital ward [ ] Hospital ER
[ ] Hospital outpatient facility [ ] Home [ ] Work [ ] College [ ] Military [ ] Correctional facility [ ] Place of worship
[ ] Laboratory [ ] Long term care facility [ ] Homeless/shelter [ ] International travel [ ] Out of state travel [ ] Transit
[ ] Social event [ ] Large public gathering [ ] Restaurant [ ] Hotel/motel/hostel [ ] Other _____________________________

Describe _____________________________

Exposure summary

Suspected transmission type (check all that apply) [ ] Foodborne [ ] Waterborne [ ] Animal related [ ] Vectorborne
[ ] Person to person [ ] Sexual [ ] Blood products [ ] IDU [ ] Healthcare Associated [ ] Unk [ ] Other _____________________________

Describe _____________________________

Suspected transmission setting (check all that apply) [ ] Daycare/Childcare [ ] School (not college) [ ] Doctor’s office
[ ] Hospital ward [ ] Hospital ER [ ] Hospital outpatient facility [ ] Home [ ] Work [ ] College [ ] Military
[ ] Correctional facility [ ] Place of worship [ ] Laboratory [ ] Long term care facility [ ] Homeless/shelter
[ ] International Travel [ ] Out of state travel [ ] Transit [ ] Social event [ ] Large public gathering [ ] Restaurant
[ ] Hotel/motel/hostel [ ] Other _____________________________

Describe _____________________________

Public Health Interventions/Actions

Y    N   Unk
[ ] [ ] Facility notified
[ ] [ ] Home isolation instructions given   Date given ___/___/___
[ ] [ ] Follow-up of appropriate contacts
[ ] [ ] Number recommended for quarantine _______
[ ] [ ] Contact quarantine instructions given
[ ] [ ] Letter sent   Date ___/___/___   Batch date ___/___/___

TRANSMISSION TRACKING

Visited, attended, employed, or volunteered at any public settings while contagious [ ] Yes [ ] No [ ] Unk

Settings and details (check all that apply) [ ] Daycare [ ] School [ ] Airport [ ] Hotel/Motel/Hostel [ ] Transit [ ] Healthcare [ ] Home [ ] Work [ ] College
[ ] Military [ ] Correctional facility [ ] Place of worship [ ] International travel [ ] Out of state travel [ ] LTCF
[ ] Homeless/shelter [ ] Social event [ ] Large public gathering [ ] Restaurant [ ] Other

<table>
<thead>
<tr>
<th>Setting Type (as checked above)</th>
<th>Setting 1</th>
<th>Setting 2</th>
<th>Setting 3</th>
<th>Setting 4</th>
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<tbody>
<tr>
<td>Facility Name</td>
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<tr>
<td>Start Date</td>
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<td>End Date</td>
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<tr>
<td>Time of Arrival</td>
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<td>Time of Departure</td>
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<tr>
<td>Number of people potentially exposed</td>
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<tr>
<td>Details (hotel room #, HC type, transit info, etc.)</td>
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<tr>
<td>Contact information available for setting (who will manage exposures or disease control for setting)</td>
<td>Y   N   Unk</td>
<td>Y   N   Unk</td>
<td>Y   N   Unk</td>
<td>Y   N   Unk</td>
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<tr>
<td>Is a list of contacts known?</td>
<td>Y   N   Unk</td>
<td>Y   N   Unk</td>
<td>Y   N   Unk</td>
<td>Y   N   Unk</td>
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</tbody>
</table>

If list of contacts is known, please fill out Contact Tracing Form Question Package
### TREATMENT

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
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**Did patient receive influenza antiviral medication prior to becoming ill (within 2 weeks) or after becoming ill**

*If Yes, please list any antiviral medications in the prophylaxis/treatment section below*

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**Did patient receive prophylaxis/treatment**

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**Specify medication**

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**Number of days actually taken**

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**Treatment start date**

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**Treatment end date**

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**Prescribed dose**

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**g** | **mg** | **ml**

**Frequency**

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**Duration**

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| ☐ | ☐ | ☐ | ☐ |

**Indication**

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*PEP* | Treatment for disease | Incidental | Other

**Did patient take medication as prescribed**

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**Prescribing provider**

---

### LAB RESULTS

**Lab report information**

- **Lab report reviewed – LHJ**

WDRS user-entered lab report note

**Submitter**

---

**Perfoming lab for entire report**

---

**Referring lab**

---

**Specimen**

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**Specimen identifier/accession number**

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**Specimen collection date**

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**Specimen received date**

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**WDRS specimen type**

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**WDRS specimen source site**

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**WDRS specimen reject reason**

---

**Test performed and result**

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**WDRS test performed**

---

**WDRS test result, coded**

---

**WDRS test result, comparator**

---

**WDRS result, numeric only** (enter only if given, including as necessary Comparator and Unit of measure)

---

**WDRS unit of measure**

---

**Test method**

---

**WDRS interpretation code**

---

**Test result – Other, specify**

---

**WDRS result summary**

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**Test result status**

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**Final results: Can only be changed with a corrected result**

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**Preliminary results**

---

**Record coming over is a correction and thus replaces a final result**

---

**Results cannot be obtained for this observation**

---

**Specimen in lab; results pending**

---

**Result date**

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### Upload document

**Ordering Provider**

---

**WDRS ordering provider**

---

**Ordering facility**

---

**WDRS ordering facility name**

---