

CALIFORNIA DEPARTMENT OF HEALTH SERVICES SCREENING FORM FOR SUSPECT AVIAN (H5N1) INFLUENZA

Patient's Last Name: _____ First Name: _____

Address: _____ City: _____ County: _____

Date of Birth ___/___/___ or Age: _____ Race: _____ Gender: Male Female

Occupation (if HCW, note type and if direct patient care involved): _____

EPIDEMIOLOGIC/TRAVEL HISTORY (within 10 days prior to symptom onset):

NOTE: Refer to http://www.who.int/csr/disease/avian_influenza/en/ for an updated list of affected countries.

Did the patient travel to an area with documented avian (H5N1) influenza in birds and/or humans? Yes No Unk

If yes, list country (ies) and dates of travel: _____

Did the patient have contact with poultry? Yes No Unk If yes, were the poultry sick or dying? Yes No Unk

If yes, state nature of contact (e.g. direct handling of live or butchered poultry, visiting food markets with live birds, etc): _____

Was patient in close contact or stay in same household with a known/suspected human case of H5N1? Yes No Unk

Was patient in close contact/stay in same household with anyone with pneumonia or severe flu-like illness? Yes No Unk

CLINICAL INFORMATION/HOSPITAL COURSE

Date of symptom onset: ___/___/___ Date of first clinical evaluation: ___/___/___

Is patient hospitalized? Yes No Unk If yes: Name of hospital and county: _____

Date of admission: ___/___/___ Date of discharge: ___/___/___

Is patient in the ICU? Yes No Unk Intubated? Yes No Unk

Symptoms: (e.g., fever, chills, myalgias, headache, cough, sore throat, n/v, alt mental status, seizures, etc) Documented temp: _____ O₂ sat: _____

Notes on hospital course, complications (e.g., ARDS, bacterial pneumonia, encephalitis, sepsis/MOF, etc) and antibiotics/antivirals received: _____

Past Medical History (also note risk factors for influenza complications, e.g. cardiopulmonary disease, immunosuppression, pregnancy, etc) : _____

Laboratory: WBC with diff: _____ Hct: _____ Platelet: _____ Liver function: AST:_____ ALT: _____

Chest X-ray/CT: _____ Date: ___/___/___

Did the patient die? Yes No Unk If yes, date of death: ___/___/___ Was autopsy performed? Yes No Unk

MICROBIOLOGY RESULTS FROM CLINIC/HOSPITAL/LPHL (e.g., rapid antigen testing, bacterial/viral culture, PCR, biopsy/path results):

Reporting LHD/physician contact: _____ Phone/fax: _____

**TO REQUEST DIAGNOSTIC TESTING,
call Janice Louie, Carol Glaser, or David Schnurr at VRDL (510-307-8575)
or the CDHS DCDC Duty Officer
and FAX THIS FORM TO 510-307-8599**