



**Patient/Proxy PROTECTED INFORMATION – LOCAL USE ONLY – DO NOT FORWARD THIS SECTION TO PHAC**

**PATIENT Contact Information:**

Last name: \_\_\_\_\_

First name: \_\_\_\_\_

Usual residential address: \_\_\_\_\_  
 \_\_\_\_\_

City: \_\_\_\_\_

Province/Territory: \_\_\_\_\_ Postal code: \_\_\_\_\_

Phone number(s): (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Local Contact Information (if different from residential):

Phone number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Number valid until (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

**HOSPITAL Information:**

Name of hospital: \_\_\_\_\_

**PROXY Information:**

**Is respondent a proxy?** (e.g. for deceased patient, child)

No  Yes (complete information below)

Proxy Last name: \_\_\_\_\_

Proxy First name: \_\_\_\_\_

Proxy Relationship to case: \_\_\_\_\_

Proxy Phone number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Please send completed forms to the Office of the Chief Medical Health Officer:**

**Confidential Fax (867) 873-0442**

## Pandemic (H1N1) 2009 Flu Virus Case Report Form

Only Confirmed Cases to be Reported to Public Health Agency of Canada (PHAC)

<b>Provincial/Territorial Case ID:</b> _____	<b>TO BE COMPLETED BY PHAC:</b> Date received by PHAC: ____/____/____ (dd/mm/yyyy) PHAC ID: _____	
<b>SECTION 1: ADMINISTRATIVE INFORMATION</b>		
Laboratory confirmation of Pandemic (H1N1) 2009 flu virus infection with or without clinical symptoms by one or more of the following test: <input type="checkbox"/> RT-PCR <input type="checkbox"/> Viral Culture <input type="checkbox"/> Four-fold rise in Pandemic (H1N1) 2009 flu virus specific neutralizing antibodies	<input type="checkbox"/> Confirmed  <input type="checkbox"/> Probable	
<b>Report Status</b> <input type="checkbox"/> Initial Report <input type="checkbox"/> Update	<b>Date of initial report</b> (dd/mm/yyyy): ____/____/____ <b>Date of this update</b> (dd/mm/yyyy): ____/____/____	
<b>Name/affiliation of person making report:</b> _____		<b>Reporting Province /Territory:</b> _____ <b>Reporting Health Unit:</b> _____
<b>Reporting contact phone no:</b> (____) ____ - ____ ext ____		
<b>SECTION 2: PATIENT INFORMATION</b>		
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <b>Date of birth:</b> ____/____/____ (dd/mm/yyyy) <b>Age:</b> ____ years, <input type="checkbox"/> Age unknown If under 2 years of age, please specify ____ months	<input type="checkbox"/> Inuit <input type="checkbox"/> Métis <input type="checkbox"/> First Nations (FN): If FN, does this person live primarily on reserve? <input type="checkbox"/> Yes <input type="checkbox"/> No If FN, is this person a 'Registered Indian'? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>SECTION 3: CLINICAL INFORMATION</b>		
<b>Date of onset of first symptom(s)</b> (dd/mm/yyyy): ____/____/____ <b>Symptoms (check all that apply):</b>		
<input type="checkbox"/> fever <input type="checkbox"/> cough <input type="checkbox"/> sore throat <input type="checkbox"/> arthralgia <input type="checkbox"/> myalgia <input type="checkbox"/> malaise	<input type="checkbox"/> prostration <input type="checkbox"/> rhinorrhea or nasal congestion <input type="checkbox"/> sneezing <input type="checkbox"/> shortness of breath <input type="checkbox"/> sputum production <input type="checkbox"/> chest pain	<input type="checkbox"/> diarrhea <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> conjunctivitis <input type="checkbox"/> headache <input type="checkbox"/> seizures  <input type="checkbox"/> altered level of consciousness <input type="checkbox"/> nose bleed <input type="checkbox"/> encephalitis <input type="checkbox"/> other, specify: _____
Date of initial hospital admission (dd/mm/yyyy): ____/____/____ Date of final hospital discharge (dd/mm/yyyy): ____/____/____		
<b>Course of Illness/Severity:</b> Admitted to ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know On oxygen therapy during any of the hospital stays? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Ventilated during any of the hospital stays? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Pneumonia diagnosed by chest x-ray or CT scan? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Diagnosed with Acute Respiratory Distress Syndrome (ARDS) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know		
<b>Disposition at time of report:</b> <input type="checkbox"/> Stable <input type="checkbox"/> Deteriorating <input type="checkbox"/> Recovering <input type="checkbox"/> Died (indicate date/cause below) <input type="checkbox"/> Unknown <b>If patient died,</b> Date of death (dd/mm/yyyy): ____/____/____ Cause of death (specify): _____		

**SECTION 4: MEDICAL AND VACCINE HISTORY**

**Treatment: Is patient taking prescribed antivirals?**  Yes  No  Don't Know

**If yes, Specify name:** \_\_\_\_\_

Start date (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ End date (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

**Response to antivirals treatment?** Improvement No change Deterioration

**Did patient receive this year's seasonal human influenza vaccine?**  Yes  No  Don't Know

**If yes, date of vaccination (dd/mm/yyyy):** \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION 5: UNDERLYING CONDITIONS and RISK FACTORS**

Chronic lung disease  Yes  No  Don't Know

Asthma  Yes  No  Don't Know

Chronic heart disease  Yes  No  Don't Know

Diabetes  Yes  No  Don't Know

Chronic liver disease  Yes  No  Don't Know

Kidney disease  Yes  No  Don't Know

Immune suppressed  Yes  No  Don't Know

Anemia or Hemoglobinopathy  Yes  No  Don't Know

Neurodevelopmental condition  Yes  No  Don't Know

Musculoskeletal condition impairing respiratory function  Yes  No  Don't Know

Pregnancy  Yes  No  Don't Know , *If yes, weeks of gestation (or trimester):* \_\_\_\_\_

Adverse fetal outcome:  Spontaneous abortion  Stillbirth/fetal death

Obesity (BMI >35 or visual assessment)  Yes  No  Don't Know, Height: \_\_\_\_ (inches/cms) Weight: \_\_\_\_ (pounds/kgs)

Current smoking  Yes  No  Don't Know

Other condition/risk, specify: \_\_\_\_\_

**SECTION 6: LABORATORY TESTING**

**Outbreak Number:** \_\_\_\_\_

Date Specimen Collected (dd/mm/yyyy)	P/T Lab Specimen Number	Specimen Source	Test Method	Test Result	Date Test Performed (dd/mm/yyyy)	Laboratory Performing Test

\*Recommended specimens for optimal investigation of influenza include: nasopharyngeal swab; nasal swab; bronchoalveolar lavage (BAL); serum (as per consultation with NML)

**SECTION 7: EXPOSURES**

**Is the patient:**

A health care worker exposed to SRI patient(s) under investigation

Exposed to a person who is part of a cluster of Pandemic (H1N1) 2009 or SRI . Please describe location of cluster:

Acute care facility  Long term care facility  School-based  Community-based

A laboratory worker working directly with emerging or re-emerging pathogens

In contact with any of the following animals within 7 days after symptom onset:

swine  poultry  other (e.g. mink, ferrets): \_\_\_\_\_

**SECTION 8: SUMMARY OF CLOSE CONTACTS\* IN THE 7 DAYS PRIOR TO SYMPTOM ONSET**

**Total # contacts:** \_\_\_\_\_

Household contacts: \_\_\_\_\_  Workplace contacts: \_\_\_\_\_

Other close contacts: \_\_\_\_\_ (i.e. social)

*\*Close contact: having cared for, lived with, or had direct contact with respiratory secretions or body fluids of a probable or confirmed case of human swine influenza.*

