



Center for Community Health and Disease Control

Republic Of Maldives

Influenza A H1N1 Case Reporting Form

This form is to be used to obtain important information to determine severity and clinical characteristics of the cases infected with Influenza A H1N1 to Center for Community Health and Disease Control by Fax 3314635.

• **1. Submitter Information**

Name of Submitter: _____	Date of Submission: _____
Email/Telephone Number: _____	

• **2. Case Information**

Full Name: _____	Address: _____
Date of Birth: _____	Age (Years): _____
Sex: Male <input type="checkbox"/>	Female <input type="checkbox"/>

• **3. Current Diagnosis classification. Please tick**

Confirmed <input type="checkbox"/>	Probable <input type="checkbox"/>	suspected <input type="checkbox"/>
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Laboratory Test

- Date of first sample positive for swine Influenza: _____
- Name of laboratory sample was sent : _____

- **4. Symptoms**

- Date of onset of symptoms (directly related to disease): _____

- ***Symptoms at disease onset:***

	Yes	No	Unk	Comment
Fever _≥ 38 ⁰ c	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
History of Fever (temp not measured)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dry Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Productive cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Altered Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Epistaxis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

- **5. History and Pre-existing conditions**

- Did the patient have any of the following vaccines or treatments prior to illness onset?

	Yes	No	Unknown	Comment
Vaccination with seasonal influenza Vaccine within the last year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vaccination with swine Influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Vaccination with pneumococcal vaccine?

Use of antivirals as prophylaxis in the 14 Days before onset of illness?

	Amantadine	<input type="checkbox"/>
	Rimantadine	<input type="checkbox"/>
	Oseltamivir	<input type="checkbox"/>
	Zanamivir	<input type="checkbox"/>
	Other (specify)	

- Did the patient have any pre-existing conditions? Check on field for each condition

	Yes	No	Unknown
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV/ other immune	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/> ____ months	<input type="checkbox"/>	<input type="checkbox"/>
Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other ____ (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 6. Exposure/Possible Exposure**

- 6.1. Exposure (contact within touching/speaking distance) in the 7 days before onset of illness to confirmed or probable swine influenza A H1N1 case

Yes No Unknown if no go to 6.2

If yes,

	Yes	No	Unk	
Single Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	please enter date of likely exposure ____/____/____
Multiple exposure (exposure to multiple Unlinked confirmed or Probable cases)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	And person exposed to (unique identifier) Please enter dates of likely exposure ____/____/____ to ____/____/____ and person exposed to unique to (unique identifier)

	_____ __/__/__ to __/__/__
	And person exposed to (unique identifier)
	_____ __/__/__ to __/__/__
	And person exposed to (unique identifier)
Continuous exposure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Please enter dates of likely first exposure _____ __/__/__ to __/__/__ And person exposed to (unique identifier) _____

a. Exposure in a household with a confirmed or probable swine influenza A H1N1 case

Yes NO Unknown

b. Patient provided care to swine influenza A H1N1

Yes NO Unknown

- 6.2 Patients has an occupation in health care setting
Please tick if yes

	Yes	No	Unknown
Health care workers dealing directly with patients (including doctors, nurses, health care students, health volunteers, allied health professionals, catering staff, cleaners, ambulance staff and community health workers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Workers in laboratory dealing with influenza viruses And/or other respiratory samples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 6.3 Travel outside of residential province in the 7 days prior to onset of symptoms?

Yes No Unknown if yes specify below

Country _____	Province _____
Dates _____	

Country _____	Province _____
Dates _____	

Follow-up questionnaire

This form should be filled out after the patient has died or after at least 14 days after the onset of symptoms. Data may be obtained from case interviews and/or hospital charts.

Patient ID: _____

Date of follow up / /

- **7 Final classification**

Please tick

Confirmed	Probable	Suspected	Discharged	Lost to follow up
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- **8 Outcome**

Death	Recovered	Hospitalized	Convalescent	Lost to follow up
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- **9 Disease dates (yyyy/mm/dd)**

Dates of first Presentation to health Care facility	___/___/___	Dates of Initial Hospitalisation if relevant	___/___/___
Date of death	___/___/___	Dates of discharge from Hospital if relevant	___/___/___
Dates of resolution Of symptoms	___/___/___		

- **10 Follow up Symptoms**
- Symptoms ever during the course of the disease

	Yes	No	Unk	Comment
Fever \geq 38°C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Duration of fever (in days)_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
History of fever (temp not measured)				
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Running nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dry cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Productive cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Altered consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

- **11. Chest Radiograph**

- Was a chest x-ray taken? Yes No Unknown
- If not or unknown go to 12
- Date of first x-ray showing pneumonia? Yes No Unknown
- Date of first chest x-ray showing
Pneumonia dd/mm/yy _____/____/____

- **12 Treatments provided**

- Did the case receive antiviral treatment Yes No Unknown
- If yes, which drug

Treatment	Date started (dd/mm/yy)	Duration
Oseltamivir	____/____/____	_____

Name of WHO Reference Lab:
Result:
Type of test
PCR Culture Serology Other
(2 different PCR targets) (virus isolation) (fourfold rise)
Specify: _____
Type of Sample
Respiratory Serum/Plasma other
(specify): _____

ANNEX 1 Specimen collection form

Specimen collection form (human case)					
Name of person taking the specimen (s)			Contact details for specimen collector (phone no, email address)		
Date of birth of patient (dd/mm/yy)		Given name(s) of patient		Family name of patient	
Sex of Patient M <input type="checkbox"/> F <input type="checkbox"/>		Nationality		Occupation	
Patient's Hospital/ Clinic number					
Patient's address (if available-or a suitable contact address):					
House Number or Name: _____			Street Name: _____		
Town: _____			District: _____		
Postal Code: _____			Country: _____		
Place where specimens taken					
Hospital: Yes <input type="checkbox"/> No <input type="checkbox"/>		Clinic: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Others(specify): _____		Home Address: _____			
Unique identifyin number	Type of specimen	Date of Collection	Clinical Diagnosis	Health of Patient when specimen collected	Remarks