Services de santé du TIMISKAMING Health Unit

External Sporadic Influenza Report Form

(**Complete for nasopharyngeal swabs submitted)

Client:

♦Name			
♦D.O.B.	_____ (YEAR/MM/DD)	♦Gender	☐ Male ☐ Female

Immunization: Influenza Vaccination for current season?

☐ Yes ☐ No ☐ Unknown (If Yes, complete this section as much as possible)

	♦ Administration Date (YEAR/MM/D)	♦Provider (i.e. HCP or facility)	♦ Agent	♦ Lot Number	♦Site
			☐ Inf - Influenza	☐ _____	☐
			☐ Inf - Influenza	☐ _____	☐

*if Administration Date is unknown, use yyyy-mm-01 (if month and year are known) or yyyy-01-01 (if only year is known)

Interventions: Note: An ER visit only is not considered hospitalization

Interventions	♦Intervention Type	♦Start Date (YEAR/MM/DD)	♦End Date (YEAR/MM/DD)	♦Provider	♦Location
	☐ Education				
	☐ Isolation				
	☐ ER Visit				
	☐ Hospitalization				
	☐ ICU				
	☐ Ventilator				
	☐ Chemoprophylaxis				

Risk Factors

Medical Risk Factors	Medical Risk Factors If no boxes are checked – then assume data entry response is 'not asked'	Response (X)			
		Yes	No	Unknown	Not Asked
	Anemia or hemoglobinopathy				
	Asthma				
	Cancer (specify)_____				
	Cardiovascular conditions (specify)_____				
	Chronic illness/underlying medical condition (specify)_____				
	Immunocompromised (specify)_____				
	Other (specify)_____				
	Pregnant				
	Conditions that compromise respiratory secretion clearance				
	COPD				
	Diabetes				
	Not Immunized - Influenza				
	Not properly/adequately immunized - Influenza				
	Other pulmonary conditions (specify)_____				
	Renal conditions (specify)_____				
	Treated for long periods with ASA				
	Unknown				

Behavioural Risk Factors	Behavioural Risk Factors If no boxes are checked – then assume data entry response is 'not asked'	Response (X)			
		Yes	No	Unknown	Not Asked
	Contact with birds/poultry or their environment _____				
	Occupational – farm worker				
	Other (specify)_____				
	Resident of nursing home or other chronic care facility				
	Travel outside province in the 3 days prior to illness (specify)_____				
	Unknown				

Outcome: ☐ Fatal (If client is deceased, complete the Outcome box below)

Outcome	♦ Outcome	Outcome Date (YEAR/MM/DD)	
	☐ **Fatal** *(if fatal, create Demo pop-up)*		
	♦ Cause(s) of Death?	Primary: 1)	Secondary: 1) 2)
	Source	☐ Death Certificate ☐ Other Specify:_____	
	♦Type of Death	☐ Reportable Disease Contributed to but was not the Underlying Cause of Death ☐ Reportable Disease was the Underlying Cause of Death ☐ Reportable Disease was unrelated to the Cause of Death ☐ Unknown	
	Death Related to Outbreak?	☐ Yes ☐ No	**If yes, Outbreak #:** _____

Rx Treatment – Case:

Purpose of Medication	Drug	Dose/ Unit	Route	Start Date (YEAR/MM/DD)	End Date (YEAR/MM/DD)
☐ Treatment	☐ Amantadine (Symmetril)				
☐ Treatment	☐ Relenza (Zanamivir)				
☐ Treatment	☐ Oseltamivir (Tamiflu)				
☐ Treatment	☐ Other				
☐ Treatment	☐ Other				

Complications: ☐ Yes ☐ No ☐ Unknown (If yes, complete Complications box below)

	♦ Complication		
	☐ Encephalopathy ☐ Febrile seizures ☐ Myocarditis ☐ Myositis	☐ Otitis media ☐ Pericarditis ☐ Pneumonia, bacterial ☐ Pneumonia, viral ☐ Transverse myelitis	☐ Other (Specify)

Completed by;_____ Date:_____