



**Swine Influenza Case Report Form**  
 Texas Department of State Health Services  
 Emerging and Acute Infectious Disease Branch, MC 1960  
 P.O. Box 149347  
 Austin, Texas 78714-149347  
 Ph: (512) 458-7676 Fax: (512) 458-7616



<b>S P E C I M E N</b>	State EPI ID # (epidemiology ID) _____	CDC EPI ID # _____
	State lab specimen ID #1 _____	CDC lab specimen ID #1 _____
	State lab specimen ID #2 _____	CDC lab specimen ID #2 _____
	CDC (lab) unique ID # _____	
<b>I D</b>	<b>Reported by:</b>	
	State: _____ County: _____ Date reported to state/local health department ___/___/___	
	Name of Person Reporting to State: Last Name: _____ First Name: _____	
	Phone Number :( _____ ) _____ - _____ Fax Number :( _____ ) _____ - _____ E-Mail: _____	
<b>P A T I E N T  D A T A</b>	<b>Name:</b> _____	
	Last _____	First _____ MI _____
	<b>Address:</b> _____	
	Street _____	City _____
	_____ County _____ State _____ Zip Code _____	Home Phone ( _____ ) _____
		Mobile Phone ( _____ ) _____
	<b>DOB:</b> ___/___/___ <b>Age:</b> _____ <b>Sex:</b> _____	
	<b>Race:</b> _____ W=White; B=Black/African American; N=American Indian/Alaska Native; P=Native Hawaiian/Pacific Islander; A=Asian; O=Other; U=Unknown	
	<b>Ethnicity:</b> _____ H=Hispanic or Latino; N=not Hispanic or Latino; U=Unknown	
	<b>Student :</b> <input type="checkbox"/> No <input type="checkbox"/> Yes at: _____ (School) <b>Grade Level:</b> _____	
<b>DSHS Employee :</b> <input type="checkbox"/> No <input type="checkbox"/> Yes at: _____ (Central Office or Name of HSR / Hospital)		
<b>Is the patient pregnant:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Is the patient a resident of a long-term care facility?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes - Name of facility: _____		
<b>Is the patient associated with a day-care facility?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes		
<b>C L I N I C A L  D A T A</b>	<b>Date of Symptom Onset:</b> ___/___/___ <b>Duration of illness:</b> _____	
	<b>Signs and Symptoms (Check all that apply):</b>	
	<input type="checkbox"/> Cough <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Diarrhea <input type="checkbox"/> Feverishness (Temperature not taken)	
	<input type="checkbox"/> Fever greater than 37.8 C (100 F) <input type="checkbox"/> Headache <input type="checkbox"/> Muscle aches <input type="checkbox"/> Rhinorrhea (runny nose) or nasal congestion Max Temp _____	
	<input type="checkbox"/> Seizures <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sore throat <input type="checkbox"/> Vomiting <input type="checkbox"/> Other (Specify _____)	
	<b>Was the patient vaccinated against human influenza in the past year:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
	If yes, date of vaccination ___/___/___	
Type of vaccine: <input type="checkbox"/> Inactivated <input type="checkbox"/> Live attenuated <input type="checkbox"/> Unknown		

Did the patient receive antiviral medication :  No  Yes  Unknown

If yes, complete table below

Drug	Date Initiated	Date Discontinued	Dosage (if known)
Oseltamivir			
Zanamivir			
Rimantidine			
Amantadine			
Other _____			

Leukopenia (white blood cell count <5,000 leukocytes/mm3)  No  Yes  Unknown

Lymphopenia (total lymphocytes <800/mm3 or lymphocytes <15% of total WBC)  No  Yes  Unknown

Thrombocytopenia (total platelets <150,000/mm3)  No  Yes  Unknown

Does the patient have any underlying medical conditions?  No  Yes  Unknown

Patient chronic health conditions? (Check all that apply):  Asthma  Chronic lung disease  
 Chronic heart or circulatory disease  Metabolic disease (including Diabetes Mellitus)  Kidney disease  
 Cancer in the last 12 months  Smoker  Other chronic disease \_\_\_\_\_

Does the patient have compromised immune function such as HIV infection, chronic corticosteroid therapy, \or organ transplantation recipient?  No  Yes  Unknown

If yes, please specify \_\_\_\_\_

Was the patient hospitalized:  No  Yes  Unknown

Date of admission: \_\_\_/\_\_\_/\_\_\_ Date of discharge: \_\_\_/\_\_\_/\_\_\_

Name and location of hospital: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Was the patient admitted to the intensive case unit?  No  Yes  Unknown

Did the patient require mechanical ventilation?  No  Yes  Unknown

Did the patient have a chest x-ray or CAT scan performed?  Normal  Abnormal  Test not performed  Unknown

If abnormal:

Was there evidence of pneumonia?  No  Yes  Unknown

Did this patient have acute respiratory distress syndrome?  No  Yes  Unknown

Did the patient die as a result of this illness?  No  Yes  Unknown

If yes, date of death: \_\_\_/\_\_\_/\_\_\_

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Test 1 Date collected: \_\_/\_\_/\_\_

Specimen type:

- NP swab  NP aspirate  Nasal aspirate  Sputum  Oropharyngeal swab  Endotracheal aspirate
- Chest tube fluid  Bronchoalveolar lavage specimen (BAL)  Serum  Other

Test type:

- RT-PCR  Direct fluorescent antibody (DFA)  Viral culture  Rapid antigen test

Test result:

- Influenza A  Influenza B  Influenza type unknown  Negative  Pending

If test result is influenza A positive, is it unsubtypeable (negative for human H1 and H3)  Yes  No  Not done  Serology

If test result was an unsubtypeable influenza A, was it confirmed to be swine influenza A (H1)?  Yes  No  Not done

Test 2 Date collected: \_\_/\_\_/\_\_

Specimen Type:

- NP swab  NP aspirate  Nasal aspirate  Sputum  Oropharyngeal swab  Endotracheal aspirate
- Chest tube fluid  Bronchoalveolar lavage specimen (BAL)  Serum  Other

Test type:

- RT-PCR  Direct fluorescent antibody (DFA)  Viral culture  Rapid antigen test

Test result:

- Influenza A  Influenza B  Influenza type unknown  Negative  Pending

If test result is influenza A positive, is it unsubtypeable (negative for human H1 and H3)  Yes  No  Not done  Serology

If test result was an unsubtypeable influenza A, was it confirmed to be swine influenza A (H1)?  Yes  No  Not done

Indicate when and what type of specimens (including sera) were sent to CDC

\_\_/\_\_/\_\_ Specimen type \_\_\_\_\_

\_\_/\_\_/\_\_ Specimen type \_\_\_\_\_

\_\_/\_\_/\_\_ Specimen type \_\_\_\_\_

The following questions concern the 10 days prior to illness onset:

Did the patient travel to Mexico?  No  Yes  Unknown

Total number of individuals who live in the same household as the patient (including case patient) \_\_\_\_\_

Does the patient have family members or close contacts with pneumonia or influenza-like illness?

- No  Yes – Total number \_\_\_\_\_  Unknown

Number of family members or close contacts receiving anti-viral prophylaxis: \_\_\_\_\_

Did the patient have close contact (within 2 meters (6 feet)) with a person (e.g. caring for, speaking with, or touching) who is a suspected, probable or confirmed swine influenza case?  No  Yes  Unknown

Did the patient handle samples (animal or human) suspected of containing influenza virus in a laboratory or other setting?

- No  Yes  Unknown

Does the patient work in a health care facility or setting :

- No  Yes at: \_\_\_\_\_ (Facility Name)  Unknown