

Case Investigation Form: Request for Avian Influenza testing

SPECIMEN DETAILS

Type of sample: Nasopharyngeal (NP) swab Oropharyngeal (OP) swab Nasal swab (NS) Sputum
 Other, specify _____ **Date specimen collected:** DD/MM/YYYY

PATIENT DETAILS

SA Identity /Passport number _____
Hospital/Clinic no: _____
Surname: _____
First Name: _____
DOB: DD/MM/YYYY **Age:** _____ years
Gender: Male Female
Contact number 1: _____
Contact number 2: _____
Company/farm employed: _____
Occupation:
 Farm worker Animal laboratory worker
 Poultry Seller Factory worker
 Veterinarian Owner
 Field worker / technician Farmers' or owners' family
 Other /specify: _____

CLINICIAN/INTERVIEWER DETAILS

Surname: _____
First name: _____
Contact number: _____
Facility name: _____

FOR LABORATORY USE ONLY

CLINICAL PRESENTATION (IN PREVIOUS 10 DAYS)

Symptoms (tick all that apply) : Measured fever ($\geq 38^{\circ}\text{C}$) Self-reported fever Cough Chills
 Sore throat Runny nose Conjunctivitis Difficulty breathing Other _____
Date symptom onset symptom (First symptom) : DD/MM/YYYY N/A*

EXPOSURE HISTORY

In the 14 days before symptom onset did the patient have contact with sick or dead birds or did the patient have contact with a setting where sick/dead birds are/were kept? Yes No Unknown

If yes, was the patient involved in any of the following activities? (mark all that apply)

Touching sick/dead birds	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Slaughtering of birds	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sawing through breast-bone	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Culling	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Stunning, throat-slitting, bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Deboning of carcasses	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Plucking/ de-feathering	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Transporting birds	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Removal of internal organs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Post mortem on birds	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Gathering or moving birds	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Feeding of birds	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Removing/cleaning faeces	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Preparing/cleaning cages	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cleaning contaminated equipment or environmental decontamination	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

Other, specify: _____

If yes to any of the above activities, how long did they spend in contact with sick/dead birds in one day? Less than 1 hour More than 5 hours
 1 to 5 hours Unknown

If yes to any of above activities, how many days did they spend in contact with sick/dead birds? 1 day 2-5 days
 More than 5 days Unknown

UNDERLYING MEDICAL CONDITIONS (Tick all that apply)

Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	HIV	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Obesity	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Pregnancy	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Kidney or renal disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Chronic Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U		
Chronic Obstructive Pulmonary Disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Other, specify:			

Y-Yes, N-No, U-Unknown *applies where testing done for asymptomatic individuals

FOR ADDITIONAL INFORMATION, PLEASE CONTACT

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