



Foirdheannacht na Seirbhíse Sláinte  
Health Service Executive

## Avian Influenza Case Surveillance

Report of Suspect, Probable or Confirmed Case of Influenza A (H5 or H5N1)



Date of Notification to Public Health Department:

Notifying Clinician:  Notifying Institute / Organisation:

Date of Report to WHO:  Date of Report to HPSC:

Name of Reporter to HPSC:  Position of Reporter:

HSE Area / Region of Reporter:  County of Reporter:

Reporter's Telephone:  Reporter's Fax:

Reporter's E-mail:

### PATIENT INFORMATION

Case ID  Surname:  Forename:

Sex: F  M  NK\*  Date of Birth:  Age (years):  Age (months):

Current Address:  County:

Telephone (Home):  Telephone (Mobile):

Country of Residence:  Country of Infection:

Ethnicity:  Occupation:

GP Surname:  GP Forename:

GP Work Phone:

GP Mobile Phone:

GP Fax:

GP Address:

GP E-mail:

### CLINICAL DETAILS

Date of 1st diagnosis:

Date of onset of symptoms:

**Current Health Status:** Recovering  Moderately ill  Severely ill  Died

**If the patient died:** Due to this ID  Not Due to this ID  Not Known  Not Specified

Date of death:  Autopsy: Yes  No  Not Known

Symptoms:	Yes	No	Not Known		Yes	No	Not Known
High fever ( $\geq 38^{\circ}\text{C}$ )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyspnoea / Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other, please specify:	<input type="text"/>		

### INVESTIGATION STATUS

Patient under investigation  Investigated, suspect influenza A H5N1

Investigated, not a case  Investigated, probable influenza A H5N1

Investigated, confirmed influenza A H5N1

\* NK = Not Known

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## HOSPITAL ADMISSION

Admitted to hospital? Yes  No  Not Known

Please complete the following table for any hospital admission (including transfers):

	Name of Hospital	Date of Admission	Was person isolated / cohorted? Yes / No / NK	Date Isolated / Cohorted	Date of Discharge
Hospital 1					
Hospital 2					

During any hospital admission, was the person mechanically ventilated?

Yes  No  Not Known

During any hospital admission, was the person admitted to ICU?

## TRAVEL RELATED

In the 7 days prior to the onset of symptoms, did the case travel or reside **OUTSIDE** Ireland?  Yes  No  Not Known

If **YES**, please give details below:

Initial City / Port of Departure:

	City / Port of Arrival	Country	From (dd/mm/yy)	To (dd/mm/yy)	Primary Mode of Transport
1.					
2.					
3.					

In the 7 days prior to the onset of symptoms did the case travel or reside in areas **WITHIN** Ireland?  Yes  No  Not Known

If **YES**, please give details:

	Address	From (dd/mm/yy)	To (dd/mm/yy)	Primary Mode of Transport
1.				
2.				
3.				

## EXPOSURE HISTORY

**a) During the 7 days prior to onset of symptoms was the case working:**

In an at-risk animal-related occupation\*?

In a laboratory where samples are tested for influenza A/H5 viruses?

As a health care worker (HCW)

Yes  No  Not Known

\* see Appendix A for list of at-risk animal-related occupations

**b) During the 7 days prior to onset of symptoms did the case have close contact (within 1 metre/3 feet), in any setting, with live or dead:**

Domestic fowl?

Wild birds?

Swine?

**c) During the 7 days prior to onset of symptoms did the case have exposure to a setting where the following were confined in the previous 6 weeks?**

Domestic fowl?

Wild birds?

Swine?

If **YES**, to any of sections a, b or c please give address details of each location:

	Address
1.	
2.	
3.	

Date 1st Exposed

Date Last Exposed

Duration of Total Exposure (Hours)

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## EXPOSURE HISTORY (continued)

If HCW, please specify type:   
If HCW, did case have direct patient care responsibilities? Yes  No  Not Known

If the case had been exposed to potentially infected poultry in the **7 days** prior to onset of symptoms were they wearing Personal Protective Equipment (PPE)? Yes  No  Not Known

If YES, date when they started wearing it?

Were they wearing any of the following during that exposure? **Please tick all that apply**

Gloves  Safety glasses  Impermeable overalls  Disposable shoes or shoe covers   
Mask  Head and hair cover  Disposable outer garments  Boots that are disinfected and worn again   
Outer garments that are worn repeatedly

During the **7 days** prior to onset of symptoms, had the case been in close contact with: Yes  No  Not Known

A confirmed case of influenza A/H5?     
A person with an unexplained acute respiratory illness that later resulted in death?     
Any other person for whom the diagnosis of influenza A/H5 is being considered?

If YES, please give details:

Exposure history unknown or undetermined: Yes  No

Is this case linked to an avian influenza outbreak? Yes  No  Not Known

If YES, is the outbreak: Already known  Newly identified

If already known, please give outbreak code:

What is the setting of this outbreak? Household/Private House  Extended Family  Recreational Camp   
Hospital  Military Barracks  Other Residential Institution

Other, please specify:

## SUMMARY OF LABORATORY RESULTS

Positive RT-PCR for influenza A/H5 or A/H5N1? Yes  No  Not Known   
Positive viral culture for influenza A/H5N1?     
Positive immunofluorescence antibody (IFA) test using influenza A/H5 monoclonal antibodies?     
4-fold rise in influenza A/H5 specific antibody titre in paired serum samples?

Were samples or isolates sent to a WHO reference laboratory for further confirmation of diagnosis of influenza A/H5 infection? Yes  No  Not Known

If YES, please specify which reference laboratory:

Please specify influenza A/H5 N subtype: N unknown  N1  N2

If known, please specify influenza A/H5 strain:

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## PROPHYLAXIS AGAINST INFLUENZA

Was the case vaccinated against seasonal influenza in the 6 months prior to the onset of symptoms? Yes  No  Not Known

If YES, in which country did the case receive it?

Was the case vaccinated against influenza A (H5N1)? Yes  No  Not Known   
Date case was vaccinated against influenza A (H5N1)?

During the **7 days** prior to onset of symptoms, was the case taking any antiviral medication? Yes  No  Not Known

If YES: Name of Antiviral: Oseltamivir phosphate (Tamiflu)  Dosage (mg)   
Zanamivir (Relenza)   
Start Date  Stop Date

Did the case take antivirals everyday? Yes  No  Not Known

## TREATMENT

Was antiviral treatment commenced? Yes  No  Not Known

If YES: Name of Antiviral: Oseltamivir phosphate (Tamiflu)   
Zanamivir (Relenza)   
Oseltamivir phosphate (Tamiflu) & Zanamivir (Relenza)   
Other antiviral

If Other antiviral, please specify:

	Start Date	Stop Date	Dosage (mg)
Oseltamivir phosphate (Tamiflu)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Zanamivir (Relenza)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other antiviral	<input type="text"/>	<input type="text"/>	<input type="text"/>

How soon after the onset of symptoms did the case begin antiviral treatment? Yes  No  Not Known

	Yes	No	Not Known
Less than 12 hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less than 24 hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less than 48 hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 48 hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Did the case take antivirals every day? Yes  No  Not Known

## CASE CLASSIFICATION

**Case Classifications:** Person under investigation  Probable influenza A (H5N1)   
Suspect influenza A (H5N1)  Confirmed influenza A (H5N1)

If Other, please specify

Date of final case classification

## FINAL CASE OUTCOME (COMPLETE ONCE FINAL OUTCOME IS KNOWN)

Date of final case outcome:

Recovered  Still ill  Died  Lost to follow-up

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## AVIAN INFLUENZA PERSONAL CONTACTS <sup>1</sup>

Reporting Region / Area:

Region / Area AI Case ID:

Please give details of all people with whom you have had close contact since the onset of your symptoms.  
This includes people who:

1	Live with you
2	Work in the same environment as you
3	Friends / family / others who have visited you / whom you have visited
4	Other close contacts

**\*Please use numbers (1-4) in table above for 'Type of Contact'**

Name & Address of Contact	Phone Number	Type of Contact*	Date of Last Contact	Is this person ill with influenza like-illness? (If YES, please indicate Onset Date)		
				Yes	No	NK
1.		<input type="checkbox"/>		Yes		
				No		
				NK		
2.		<input type="checkbox"/>		Yes		
				No		
				NK		
3.		<input type="checkbox"/>		Yes		
				No		
				NK		
4.		<input type="checkbox"/>		Yes		
				No		
				NK		
5.		<input type="checkbox"/>		Yes		
				No		
				NK		
6.		<input type="checkbox"/>		Yes		
				No		
				NK		
7.		<input type="checkbox"/>		Yes		
				No		
				NK		
8.		<input type="checkbox"/>		Yes		
				No		
				NK		
9.		<input type="checkbox"/>		Yes		
				No		
				NK		
10.		<input type="checkbox"/>		Yes		
				No		
				NK		

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<sup>1</sup> A contact of a human case is defined as a person who shared a defined setting

- ♦ household
- ♦ extended family
- ♦ hospital or other residential institution
- ♦ military barracks or recreational camps

with a person for whom the diagnosis is being considered, while the case was in their infectious period (i.e. from 1 day before onset of symptoms to 7 days after onset of symptoms, or to the date prescribed by public health).

*If more contacts, please add in AI contact sheet and staple to this form. Thank you.*



**MISCELLANEOUS COMMENTS**

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AI Case Form

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**Appendix A - List of occupations likely to have close contact with live poultry or poultry carcasses**

1. Poultry flock owners and their families
2. Poultry veterinary practitioners
3. Poultry advisors
4. DAF veterinary inspectors and other personnel involved in outbreak control measures
5. Laboratory personnel involved in poultry post mortems or poultry virology
6. Catching teams
7. Poultry transporters
8. Carcass transport and rendering plant personnel
9. Workers in the hang-on, stunning and plucking areas in slaughter plants
10. Fieldsmen
11. Vaccinators / selectors etc.
12. People involved in cleaning & disinfection of poultry houses or poultry transport
13. Personnel involved in litter removal and litter processing.