Surveillance Form for Contact of Avian source of Avian Influenza A (H5N1)

Version 1.0: August 2012

Incident ID

Name of Reporter | Position

Institution / organisation | HSE Area | County

Telephone | Mobile

E-mail: | Fax

CONTACT DETAILS

Contact ID | Date identified as a potential contact

Forename | Surname

DOB | Age | Age Type *(please tick box)* Years / Months / Weeks / Days | Sex: Female / Male

Nationality

Home Address

HSE Area | CCA / LHO | Number in household

Home Contact Details: Home | Mobile

E-mail

Occupation

If Healthcare Worker, involved in clinical care or examination of the case? **Yes** **No** **Not Known**

Work Address

HSE Area | CCA / LHO

Work Contact Details: Phone | Mobile

E-mail

GP Name: | GP Phone

GP Address

Vaccinated against most recent seasonal influenza vaccine? **Yes** **No** **Not Known**

If YES, in which country was vaccine received?

SYMPTOMS

	Yes	**No**	**Not Known**
Does the contact have symptoms?			
Conjunctivitis			
Cough			
Diarrhoea			
Dyspnoea / difficulty breathing			
Headache			
High fever ($\geq$38°C)			
Myalgia			
Sore throat			
Other			

If **Other**, please specify:

If **YES**, date of onset of symptoms

Medications:

AI Contact Form

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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

hpsc

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CONTACT EXPOSURE ASSESSMENT - CONTACT WITH AN AVIAN SOURCE OF H5N1

During the risk period* has the person had any contact with poultry, poultry products, poultry manure or sick / dead wild birds? ☐ ☐ ☐

If **YES**, when was the first contact / exposure?
When was the last contact / exposure?
Date of onset of clinical symptoms in birds

Nature of exposure:

AT RISK? **Yes** ☐ **No** ☐

If YES, proceed to Action Plan below
If NO, sign and date the form below

** 2 days before onset of clinical signs in birds until date of restriction*

ACTION PLAN *(TICK ALL THAT APPLY)*

	Yes	No	Not Known
Self-monitoring (temp check twice daily)	☐	☐	☐
Antiviral chemoprophylaxis	☐	☐	☐
GP contacted	☐	☐	☐
Passive surveillance	☐	☐	☐
Quarantine	☐	☐	☐
Vaccination with seasonal influenza vaccine	☐	☐	☐
Refer to hospital for further assessment / investigation	☐	☐	☐
Serology sample (at 1 month)	☐	☐	☐
Other actions	☐	☐	☐

Result Date

Other actions, please specify:

Details of medication:

Brand name
Generic name
Route of administration
Dose (quantity)
Dose (unit of measurement)
Frequency of administration

OUTCOME

	Yes	No	Not Known
Symptomatic?	☐	☐	☐
Avian Influenza diagnosed?	☐	☐	☐

Name (PRINTED)
Telephone:

AI Contact Form