

# WHO Swine Influenza A(H1N1) Case Summary Form for case-based data collection

This form is to be used to obtain important information to determine severity and clinical characteristics of the cases infected with Swine Influenza A(H1N1).

The data received through this form will be treated confidentially in accordance with the International Health Regulations.

## 1. Reporter Information

|                           |   |
|---------------------------|---|
| Name of reporter: _____   | Date of submission (yyyy/mm/dd) _____ / _____ / _____ |
| Name of institution _____ | Country: _____  |
| Tel. number: _____        | Email: _____  |

## 2. Case Information

|  |  |
|--|--|
| WHO Code _____                                   | National ID Or equivalent _____  |
| Date of birth (yyyy/mm/dd) _____ / _____ / _____ | Age (years) _____ unknown <input type="checkbox"/>   |
| Sex  | Male <input type="checkbox"/> Female <input type="checkbox"/> unknown <input type="checkbox"/> |
| Status of the case at submission                 | Probable <input type="checkbox"/> confirmed <input type="checkbox"/>                           |

## 3. Geographic information (Location at symptoms onset)

|                         |                          |  |
|-------------------------|--------------------------|--|
| Town/village _____      | 1. Administrative level  |  |
| Country _____           | 2. Administrative level  |  |
| Latitude (if available) | Longitude (if available) |  |

**4. Laboratory Test**

- Date of first specimen positive influenza A unsubtypeable (yyyy/mm/dd) \_\_\_\_/\_\_\_\_/\_\_\_\_
- Date of first specimen positive for Swine Influenza A(H1N1) (yyyy/mm/dd) \_\_\_\_/\_\_\_\_/\_\_\_\_

|  |  |   |                                |
|--|--|---|--------------------------------|
| Name of Laboratory: _____                          |  |   |                                |
| Type of test                                       |  |   |                                |
| PCR  | Culture                                    | Serology  | Other <input type="checkbox"/> |
| (2 different PCR targets) <input type="checkbox"/> | (virus isolation) <input type="checkbox"/> | (fourfold rise) <input type="checkbox"/>        | (specify): _____               |
| Type of specimen                                   |  |   |                                |
| Respiratory <input type="checkbox"/>               | Serum/plasma <input type="checkbox"/>      | other <input type="checkbox"/> (specify): _____ |                                |

- Specimen sent to WHO Reference Laboratory? Yes  No  Unknown

**5. Symptoms**

- Status at detection alive       dead
- Date of onset of symptoms (yyyy/mm/dd) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- Date of first presentation to health care system (yyyy/mm/dd) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- Symptoms at disease onset

|                                      | Yes                      | No                       | Unk                      | Comment |
|--------------------------------------|--------------------------|--------------------------|--------------------------|---------|
| Fever $\geq$ 38°C                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| History of fever (temp not measured) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Sore throat                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Runny nose                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Sneezing                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Dry cough                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Productive cough                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Shortness of breath                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Conjunctivitis                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Diarrhoea                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Nausea                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Vomiting                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Headache                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Seizures                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Altered consciousness                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Muscle pain                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Joint pain                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Nose bleed                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Other (specify)                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |

**6. History and Pre-Existing Conditions**

- Did the patient have any of the following vaccines or treatments prior to illness onset?

|  | Yes                      | No                       | Unknown                  | Comment |
|--|--------------------------|--------------------------|--------------------------|---------|
| Vaccination with seasonal influenza vaccine within the last year?        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Vaccination with pneumococcal vaccine?                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Use of antivirals as prophylaxis in the 14 days before onset of illness? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| <i>If yes, which</i>   |                          |                          |                          |         |
| Oseltamivir  | <input type="checkbox"/> |                          |                          |         |
| Zanamivir  | <input type="checkbox"/> |                          |                          |         |
| Amantadine   | <input type="checkbox"/> |                          |                          |         |
| Rimantadine  | <input type="checkbox"/> |                          |                          |         |
| Other (specify)  | <input type="checkbox"/> |                          |                          |         |

- Did the patient have any pre-existing conditions?

|                             | Yes                                   | No                       | Unknown                  |
|-----------------------------|---------------------------------------|--------------------------|--------------------------|
| Cancer                      | <input type="checkbox"/>              | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes                    | <input type="checkbox"/>              | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV/other immune deficiency | <input type="checkbox"/>              | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart disease               | <input type="checkbox"/>              | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizure disorder            | <input type="checkbox"/>              | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung disease                | <input type="checkbox"/>              | <input type="checkbox"/> | <input type="checkbox"/> |
| Pregnancy                   | <input type="checkbox"/> _____ months | <input type="checkbox"/> | <input type="checkbox"/> |
| Malnutrition                | <input type="checkbox"/>              | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____(specify)        | <input type="checkbox"/>              | <input type="checkbox"/> | <input type="checkbox"/> |

**7. Exposure/ Possible Exposure**

- In the 7 days prior to onset of symptoms the person was in an area where cases of Swine Influenza A(H1N1) virus had been identified Yes  No  Unknown

*If yes, name area* \_\_\_\_\_

- Exposure (contact within touching/speaking distance) in the 7 days before onset of illness to confirmed or probable Swine Influenza A(H1N1) case

Yes  No  Unknown

If yes,

|                 | Yes                      | No                       | Unknown                  |  |
|-----------------|--------------------------|--------------------------|--------------------------|--|
| Single exposure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Please enter date of likely exposure<br>____ / ____ / ____ |

- Patient has an occupation in a health care setting

Yes  No  Unknown

If yes,

|   | Yes                      | No                       | Unknown                  |
|---|--------------------------|--------------------------|--------------------------|
| Health care worker dealing directly with patients<br>(including doctors, nurses, health care students, health volunteers, allied health professionals, catering staff, cleaners, ambulance staff, and community health workers) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- Exposure to swine in the 7 days prior to onset of symptoms?

Yes  No  Unknown  if yes specify below

### **8. Outcome**

- Patient fully recovered Yes  No  Unknown

*if yes,* Date of resolution of symptoms (yyyy/mm/dd) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

- Patient was hospitalized during the disease course Yes  No  Unknown

*if yes,* Date of initial hospitalisation (yyyy/mm/dd) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of discharge (yyyy/mm/dd) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

- Patient died Yes  No  Unknown

*if yes,* Date of death (yyyy/mm/dd) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**9. Symptoms occurring at any time during the course of the disease**

|   | Yes                      | No                       | Unknown                  | Comment |
|---|--------------------------|--------------------------|--------------------------|---------|
| Fever $\geq 38^{\circ}\text{C}$ ( $100^{\circ}\text{F}$ ) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| History of fever (temp not measured)                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Sore throat   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Runny nose  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Sneezing  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Dry cough   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Productive cough  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Shortness of breath                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Conjunctivitis  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Diarrhoea   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Nausea  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Vomiting  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Headache  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Seizures  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Altered consciousness                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Muscle pain   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Joint pain  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Nose bleed  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| Other (specify)   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____   |

**10. Developed pneumonia**

- Did the patient show signs of clinical pneumonia      Yes  No  Unknown
- Diagnosis of primary influenza pneumonia              Yes  No  Unknown
- Diagnosis of secondary bacterial pneumonia            Yes  No  Unknown
- Was a chest x-ray taken?                                      Yes  No  Unknown   
*If no or unknown go to 12*
- Did chest x-ray show signs of pneumonia?                                      Yes  No  Unknown
- Date of first chest x-ray showing pneumonia      yyyy/mm/dd \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**11. Treatments Provided**

- Did the case receive antiviral treatment?

Yes  No  Unknown

*If yes, which drug:*

| Treatment   | Date started<br>(yyyy/mm/dd) | Duration (days) | Daily Dose |
|-------------|------------------------------|-----------------|------------|
| Oseltamivir | ____/____/____               | _____           | _____      |
| Zanamivir   | ____/____/____               | _____           | _____      |
| Amantadine  | ____/____/____               | _____           | _____      |
| Rimantadine | ____/____/____               | _____           | _____      |

- Were antiviral adverse events noted Yes  No

*If yes,*

Moderate  Severe  Life threatening  Specify type of adverse event \_\_\_\_\_

- Did the patient require mechanical ventilation Yes  No  Unknown
- Did the patient receive antibiotics Yes  No  Unknown
- Date started (yyyy/mm/dd) \_\_\_\_/\_\_\_\_/\_\_\_\_ Duration (days) \_\_\_\_\_

**12. Complications Observed During the Course of Disease** Yes  No  Unknown

If yes, please specify

**13. Other Observations/Comments**