

This recommendation or guideline is being provided by the Public Health Agency of Canada in response to the recent outbreak of H1N1 flu virus (Human Swine Flu) in North America. These documents have been developed to assist Canadian public health authorities in their surveillance activities. This advisory, recommendation or guideline is based on current available scientific evidence about this emerging disease, and is subject to review and change as new information becomes available.

Patient/Proxy PROTECTED INFORMATION – LOCAL USE ONLY – DO NOT FORWARD THIS SECTION TO PHAC	
<p style="text-align: center;">PATIENT Contact Information:</p> <p>Last name: _____</p> <p>First name: _____</p> <p>Usual residential address: _____</p> <p>_____</p> <p>City: _____</p> <p>Province/Territory: _____ Postal code: _____</p> <p>Phone number(s): (____) _____ - _____ (____) _____ - _____</p> <p>Local Contact Information (if different from residential):</p> <p>Phone number: (____) _____ - _____</p> <p>Number valid until (dd/mm/yyyy): ____/____/____</p>	<p style="text-align: center;">HOSPITAL Information:</p> <p>Name of hospital: _____</p> <p style="text-align: center;">PROXY Information:</p> <p>Is respondent a proxy? (e.g. for deceased patient, child)</p> <p> <input type="checkbox"/> No <input type="checkbox"/> Yes (complete information below) </p> <p>Proxy Last name: _____</p> <p>Proxy First name: _____</p> <p>Proxy Relationship to case: _____</p> <p>Proxy Phone number: (____) _____ - _____</p>

Please send completed forms to PHAC Surveillance and Epidemiology Group at:

HSFLUEPI@phac-aspc.gc.ca

Fax (613) 948-7550

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H1N1 Flu Virus (Human Swine Flu) Case Report Form

ONLY Confirmed Cases to be Reported to Public Health Agency of Canada (PHAC)

Please fax completed form to Public Health Agency of Canada (613) 948-7550

Provincial/Territorial Case ID: _____	TO BE COMPLETED BY PHAC: Date received by PHAC ____/____/____ (dd/mm/yyyy) PHAC ID: _____
SECTION 1: CASE DEFINITION	
Laboratory confirmation of H1N1 flu virus (Human Swine Flu) virus infection with or without clinical symptoms by one or more of the following tests: <input type="checkbox"/> RT-PCR <input type="checkbox"/> viral culture <input type="checkbox"/> Four-fold rise in swine influenza A(H1N1) virus specific neutralizing antibodies	Case Classification <input type="checkbox"/> Confirmed
<input type="checkbox"/> Laboratory test positive for influenza A, untypeable with or without clinical symptoms	<input type="checkbox"/> Probable
SECTION 2: ADMINISTRATIVE INFORMATION	
Report Status <input type="checkbox"/> Initial Report <input type="checkbox"/> Update	Date of initial report (dd/mm/yyyy): ____/____/____ Date of this update (dd/mm/yyyy): ____/____/____
Name/affiliation of person making report: _____ Reporting contact phone no: (____) ____ - ____ ext ____	Reporting Province /Territory: _____ Reporting Health Unit: _____
SECTION 3: PATIENT INFORMATION	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown Date of birth: ____/____/____ (dd/mm/yyyy) Age: ____ years, <input type="checkbox"/> Age unknown If under 2 years of age, please specify ____ months	<input type="checkbox"/> Inuit <input type="checkbox"/> Métis <input type="checkbox"/> First Nations (FN): If FN, does this person live on reserve? <input type="checkbox"/> Yes <input type="checkbox"/> No If FN, is this person a 'Registered Indian'? <input type="checkbox"/> Yes <input type="checkbox"/> No
Occupation: <input type="checkbox"/> Health Care Worker → <i>If yes, with direct patient contact?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION 4: CLINICAL INFORMATION	
Is the patient presenting with symptoms: <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify Date of onset of first symptom(s) (dd/mm/yyyy): ____/____/____ Symptoms (check all that apply):	
<input type="checkbox"/> fever <input type="checkbox"/> cough <input type="checkbox"/> sore throat <input type="checkbox"/> arthralgia <input type="checkbox"/> myalgia <input type="checkbox"/> malaise	<input type="checkbox"/> prostration <input type="checkbox"/> rhinorrhea or nasal congestion <input type="checkbox"/> sneezing <input type="checkbox"/> shortness of breath <input type="checkbox"/> sputum production <input type="checkbox"/> chest pain
<input type="checkbox"/> diarrhea <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> conjunctivitis <input type="checkbox"/> headache <input type="checkbox"/> seizures	<input type="checkbox"/> altered level of consciousness <input type="checkbox"/> nose bleed <input type="checkbox"/> encephalitis <input type="checkbox"/> other, specify: _____
Was the patient isolated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If yes, isolation date (dd/mm/yyyy): ____/____/____ Was the patient admitted to hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Date of initial hospital admission (dd/mm/yyyy): ____/____/____ Date of final hospital discharge (dd/mm/yyyy): ____/____/____	
Course of Illness/Severity: Admitted to ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know On oxygen therapy during any of the hospital stays? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Ventilated during any of the hospital stays? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Pneumonia diagnosed by chest x-ray or CT scan? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Diagnosed with Acute Respiratory Distress Syndrome (ARDS) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	

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Disposition at time of report: Stable Deteriorating Recovering Died (indicate date/cause below) Unknown
If patient died, Date of death (dd/mm/yyyy): ____/____/____ Cause of death (specify): _____

SECTION 5: MEDICAL AND VACCINE HISTORY

Treatment: Is patient taking prescribed antivirals? Yes No Don't Know

If yes, Specify name: _____

Start date (dd/mm/yyyy): ____/____/____ End date (dd/mm/yyyy): ____/____/____

Prophylaxis: Did patient receive antivirals in 14 days prior to onset of illness? Yes No Don't Know

If yes, Specify name: _____

Start date (dd/mm/yyyy): ____/____/____ End date (dd/mm/yyyy): ____/____/____

Did patient receive this year's seasonal human influenza vaccine? Yes No Don't Know

If yes, date of vaccination (dd/mm/yyyy): ____/____/____

SECTION 6: UNDERLYING CONDITIONS

Chronic heart disease Yes No Don't Know

Lung disease Yes No Don't Know

Diabetes Yes No Don't Know

Pregnancy Yes No Don't Know

Kidney disease Yes No Don't Know

If yes, weeks of gestation: _____

Immune suppressed Yes No Don't Know

Other condition, specify: _____

SECTION 7: LABORATORY TESTING

Outbreak Number: _____

Date Specimen Collected (dd/mm/yyyy)	P/T Lab Specimen Number	Specimen Source	Test Method	Test Result	Date Test Performed (dd/mm/yyyy)	Laboratory Performing Test

*Recommended specimens for optimal investigation of influenza include: nasopharyngeal swab; throat swab AND/or nasal swab; bronchoalveolar lavage (BAL); serum (as per consultation with NML)

SECTION 8: ANTIVIRAL RESISTANCE

Type of Antiviral Testing	Result
Amantadine	<input type="checkbox"/> Sensitive <input type="checkbox"/> Resistant <input type="checkbox"/> Not performed
Oseltamivir	<input type="checkbox"/> Sensitive <input type="checkbox"/> Resistant <input type="checkbox"/> Not performed
Zanamivir	<input type="checkbox"/> Sensitive <input type="checkbox"/> Resistant <input type="checkbox"/> Not performed

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SECTION 9: EXPOSURES

In the 7 days prior to symptom onset, had the patient:

1. Travelled to a country where there is confirmed H1N1 flu virus (human swine flu) Yes No

If yes, please specify country and location: _____

Date of arrival in country (dd/mm/yyyy): ____/____/____

Date of departure from country (dd/mm/yyyy): ____/____/____

2. Had close contact* with a:

- Confirmed symptomatic case of H1N1 flu virus (Human Swine Flu)
- Probable symptomatic case of H1N1 flu virus (Human Swine Flu)
- Person with ILI who recently returned from a country where there is confirmed H1N1 flu virus (Human Swine Flu)

**Close contact: having cared for, lived with, or had direct contact with respiratory secretions or body fluids of a probable or confirmed case of human swine influenza.*

Was the patient:

- A health care worker exposed to patient(s) linked to an ongoing outbreak investigation of human swine influenza
- Exposed to a person who is part of a cluster of human swine influenza. Please describe location of cluster:
 - Acute care facility Long term care facility School-based Community-based
- A laboratory worker working directly with emerging or re-emerging pathogens
- In contact with any of the following animals within 7 days after symptom onset:
 - swine poultry other (e.g. mink, ferrets): _____

SECTION 10: SUMMARY OF CLOSE CONTACTS* IN THE 7 DAYS PRIOR TO SYMPTOM ONSET

Total # contacts: _____

- Household contacts: _____ Workplace contacts: _____
- Other close contacts: _____ (i.e. social)

**Close contact: having cared for, lived with, or had direct contact with respiratory secretions or body fluids of a probable or confirmed case of human swine influenza.*