

WHO H5N1 Clinical Case Summary Form

Please fax or email to WHO Global Influenza Programme- Fax +41 22 7914878 email influenzadata@who.int

Section A- Submitter Information

Name of submitter _____	Date of submission <u>dd/mm/yy</u>
Email/Tel. number <u>enter your email address and/ or tel. n° here</u>	

Section B- Patient Information

Patient ID _____	Patient Initials <u>Patient's initials</u>
Country of residence _____	Place/city of residence _____
Age (years) _____	Sex (check one) Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of illness onset <u>dd/mm/yy</u>	Patient weight (kg) _____

Section C- Patient Outcome

Alive at discharge <input type="checkbox"/>	Unknown <input type="checkbox"/>
Date of discharge <u>dd/mm/yy</u>	
Died <input type="checkbox"/>	Date of death <u>dd/mm/yy</u>

Section D- H5 Laboratory diagnosis

Check all that apply for type of sample and type of **positive** test result at the **local/national** laboratory

For multiple samples, please use the supplementary form.

	Date of Sampling	RT-PCR	Virus Culture	Other (Specify)
Throat	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Serum/Plasma	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nasal	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tracheal	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (specify)	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Specimens tested H5N1 in WHO Reference Laboratory? Yes No

Check all that apply for type of sample and type of **positive** test result at the **WHO Reference Laboratory**

	Date of Sampling	RT-PCR	Virus Culture	Other (Specify)
Throat	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Serum/Plasma	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nasal	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tracheal	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (specify)	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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Section E- Exposure History

Most likely source of infection (check one box only):

Poultry Food Other _____(specify)
 Wild birds Human Laboratory
 Unknown

Prior to onset of illness, was the patient a contact of someone receiving antivirals for influenza? (check one)

Yes No Unknown
 If yes, check the type of drug at right (check all that apply)
 Amantadine
 Oseltamivir
 Other _____(specify)

Clinical Dataset

Section F- Symptoms on day of illness onset

Date of onset / / Place of onset _____
 (if different from place of residence)

Check one box for each symptom on day of illness onset:

	YES	NO	UNKNOWN
Altered consciousness	<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"/>
Dry cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever >38°	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucosal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Productive cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____ (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Days of illness prior to initial presentation to healthcare; _____

Was illness onset during antiviral prophylaxis? (check one)

Yes No Unknown
 If yes, type of prophylaxis:
 Amantadine
 Oseltamivir
 Other _____ (specify)

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Section G- Symptoms on first presentation to care

Date of presentation dd/mm/yy Place of presentation _____
 (if different from place of residence)

Check one box for each symptom on first presentation to care:

	YES	NO	UNKNOWN
Altered consciousness	<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"/>
Dry cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever >38°	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucosal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Productive cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____ (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section H- Symptoms first day of hospitalization (Do not fill in if patient's first presentation to care was at first place of hospitalization)

Date of hospitalization dd/mm/yy Place of hospitalization _____
 (if different from place of residence)

Total duration of hospitalization _____
 (days)

Check one box for each symptom on first day of hospitalization:

	YES	NO	UNKNOWN
Altered consciousness	<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"/>
Dry cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever >38°	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucosal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Productive cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____ (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Section I- Preexisting conditions

Did the patient have any pre-existing conditions? Check one field for each condition.

	Yes	No	Unknown
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV/immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<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"/>
Other _____ (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section J- Routine laboratory testing

First routine testing date: dd/mm/yy

	Tested	Result	Not tested	Unknown
Leucocytes (/mm ³)	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Neutrophils (%)	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Lymphocytes (%)	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Haemoglobin (g/dl)	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Bilirubin (umol/l)	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Platelet (/mm ³)	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
AST (IU/l)	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
ALT (IU/l)	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Creatinine (umol/l)	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
LDH	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

Section K- First chest radiograph

Date of first chest radiograph: dd/mm/yy

Results of first radiograph:

	Yes	No	Unknown
Normal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pleural effusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lobar consolidation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infiltrates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unilateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bilateral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date of first chest radiograph showing pneumonia dd/mm/yy

Section L- Influenza antiviral treatment provided

Was antiviral treatment provided? Yes No Unknown

Treatment	Date started	Duration (days)	Dose (mg/d)
Oseltamivir	<u>dd/mm/yy</u>	_____	_____
Zanamavir	<u>dd/mm/yy</u>	_____	_____
Amantadine/Rimantadine	<u>dd/mm/yy</u>	_____	_____
Other _____ (specify)	<u>dd/mm/yy</u>	_____	_____

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Section L- Influenza antiviral treatment provided (continued)

Antiviral adverse effects yes no uncertain
 If yes, moderate severe life threatening

Specify the type of adverse effect: _____

Was antiviral treatment stopped or dose modified because of adverse effects? yes no unknown

Section M- Other treatment provided

Treatment	Yes	No	Unknown	Date started (only applicable if treatment was provided)	Duration (days) (only applicable if treatment was provided)
Supplemental oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dd/mm/yy	_____
Mechanical ventilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dd/mm/yy	_____
Antibiotics (if yes, specify classes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dd/mm/yy	_____
Corticosteroid (if yes, specify type and dose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dd/mm/yy	_____
Immunoglobulin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dd/mm/yy	_____
Vasoconstrictors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dd/mm/yy	_____
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dd/mm/yy	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dd/mm/yy	_____

Section N- Laboratory abnormalities during care

	Yes	No	Unknown
Creatinine >2.0mg/dl 171 umol/l	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bilirubin >2.0mg/dl or 33 umol/l	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O2 saturation <92% (room air)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphocytes <1000/mm ³	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Platelets <100 000/mm ³	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section O- Secondary complications during care

	Yes	No	Unknown	Date started	Duration (days)	Etiology/comment
Bacteraemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dd/mm/yy	_____	_____
Bacterial pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dd/mm/yy	_____	_____
Shock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dd/mm/yy	_____	_____
Renal failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dd/mm/yy	_____	_____
Coagulopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dd/mm/yy	_____	_____
Other _____ (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dd/mm/yy	_____	_____

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Section P- Other observations/comments

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