Influenza A H1N1 Positive Case Summary Form

(Performa to be filled up for the Influenza A H1N1 confirmed patients)

I. Reported by:

1. Name of the hospital with address:

II. Patient Identification Data:

1. Name:_____

2. Date of Birth (dd/mm/yy) - -/- -/---- Age (in yrs): - -

3. Sex ☐ Male ☐ Female
If Female, was the patient pregnant? ☐Yes (weeks pregnant) ____☐No ☐ Unknown

4. Residential status: ☐ Urban ☐ Rural, specify address with contact telephone no. (mobile preferred) of family member

III. Clinical Data (Please tick one or more than one symptoms/ailments the patient had)

1. Signs and symptoms with date of onset (dd/mm/yy) : - -/- -/----

	Duration (in days)		Duration (in days)
☐ Mild fever	▭	☐ High grade fever	▭
☐ Cough	▭	☐ Breathlessness	▭
☐ Headache& bodyache	▭	☐ Chest pain	▭
☐ Running of nose	▭	☐ Fall in blood pressure	▭
☐ Sore throat	▭	☐ Sputum with blood	▭
☐ Vomiting	▭	☐ Any other, specify	▭
☐ Diarrhoea	▭		

2. Did the patient had any high risk illness / predisposing condition

i) Cortisone therapy + Immuno suppressive therapy Yes ☐ No ☐ Unknown ☐

ii) HIV +ve only Yes ☐ No ☐ Unknown ☐

iii) AIDS Yes ☐ No ☐ Unknown ☐

iv) Diabetes mellitus ☐Yes ☐ Controlled ☐Uncontrolled ☐ No ☐ Unknown

v) Chronic Lung disease (specify with duration) _____

vi) Chronic Heart disease (specify with duration) _____

vii) Chronic Kidney disease (specify with duration) _____

viii) Chronic Liver disease (specify with duration) _____

ix) Cancer (specify with duration) _____

x) Blood disorders (specify with duration)_____

xi) Neurological disorders (specify with duration)_____

xii) Any other (specify with duration) _____

3. Diagnostic Findings (clinical) :

3.1. General tests:

Did the patient have any of the following tests?

☐ Chest x ray If yes, ☐ Normal ☐ Abnormal ☐ Unknown

☐ Chest CT scan If yes, ☐ Normal ☐ Abnormal ☐ Unknown

If chest x- ray or chest CT scan result abnormal:
Was there evidence of pneumonia?

☐ Yes ☐ No ☐ Unknown

3.2. Influenza testing:

Date of collection of sample: ___//___//___
Date of declaration of result: :___//___//___
Name of the lab. which conducted test:

Result:

4. Treatment details

4.1. Previous treatment history

I. Oseltamivir with duration

II. Treatment for other symptoms

III. Name of the Hospitals/health facilities/private practitioner where treatment taken with dates

4.2. Treatment given in the hospital where patient died

I. Date of admission :____//__//__

II. Hospital Type (Hospital: Private/Govt.):----------

III. History of Treatment Before admission:----------

IV. Date of death: :____//__//____ Cause of Death: _____

V. Did the patient receive Oseltamivir?

a. If yes, complete table below:

Drug	**Date initiated**	**Date discontinued**	**Dosage(if known)**
Oseltamivir			
Zanamivir			

VI. Treatment for complications (details)

VII. Did the patient require mechanical ventilation? ☐ Yes ☐No ☐ Unknown

(Signature of Treating Doctor / Medical Superintendent)
Date: