Reg. under PNDT Act 1994

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CLINICAL & EPIDEMIOLOGICAL DATA FOR H1N1 INFLUENZA

Name Of Doctors/Health Personal...

District.. State...

Tel..

Name Of Hospital.......................................Ward..

Patient's Name...CR/OPD No ....

Age.........................Sex.............................Tel. No...

Address..

District..........................State.........................Occupation..

Date of onset of illness....................... Date of Admission..

Clinical Signs & symptoms:

Fever axilla>38^0C	Yes	☐	NO	☐
Oral > 38.5^0C	Yes	☐	NO	☐
Cough	Yes	☐	NO	☐
Sore throat	Yes	☐	NO	☐
Nasal catarrh	Yes	☐	NO	☐
Shortness of breath (difficulty in breathing)	Yes	☐	NO	☐

Exposure History:

Country Visit Date of visit. ☐ Name. ☐

Close contact with a person (within 7 day) who is confirmed case of influenza A (H1N1.)

Yes ☐ No ☐

Travel to community (Within 7 day) where one or more confirmed case of influenza A (H1N1) have been reported. Yes ☐ No ☐

Resides in a community where there are one or more confirmed influenza cases.

Yes ☐ No ☐

Sample Collection: Date:...........Type: throat swab/ nasopharyngeal swab/other...................

No. Of samples collected:...

Treatment History: Treatment taken Yes ☐ No ☐ If yes what & when.......................

Investigations Done: Yes ☐ No ☐

Chest X-Ray findings...................,**Email ID for reporting.......................................**

SECTION B – MEDICAL INFORMATION

B. 1 CLINICAL SYMPTOMS AND SIGNS

Symptoms: Yes Or No If No please go to B.2 section

Symptoms	yes	Symptoms	yes	Symptoms	yes	Symptoms	yes
Cough	__	Diarrhea	__	Vomiting	__	Fever at Evaluation	__
Breathlessness	__	Nausea	__	Haemoptysis	__	Body Ache	__
Sore Throat	__	Chest Pain	__	Nasal Discharge	__	Sputum	__
Abdominal Pain	__						

Which of the above mentioned was First Symptom: ……….. Date of onset of First Symptom: _________

B.2 PRE – EXISTING MEDICAL CONDITIONS

Condition	Yes	Condition	Yes	Condition	Yes
Chronic Lung Disease	__	Malignancy	__	Heart Disease	__
Chronic Renal Disease	__	Diabetes	__	Hyper tension	__
Chronic Liver Disease	__				

Immunocompromised Condition: Yes / No Other underlying conditions:……………………………….

B.3 HOSPITALIZATION DETAILS

Hospitalized: Yes / No Hospital State: …………………………………….

Hospital ID / Number: ……………..... Hospital District: …………………………………..

Hospitalization Date: __/__/__ (DD/MM/YY) Hospital Name: …………………………………….

B.4 REFFERING DOCTOR DETAILS

*Name Of Doctor: ……………………………….. Doctor Mobile No: ………………………………………………..

Doctor Email Id: …………………………………………………..

*Fields Marked with asterisk are mandatory to be filled

TEST REUSLT (To be filled by Testing lab facility)

Date of sample Receipt (dd/mm/yy)	Sample Accepted / rejected	Date of Testing (dd/mm/yy)	Test result (Positive / Negative)	Repeat Sample Required (Yes / No)	Sign of Authoriy (Lab in Charge)