

**New Jersey Department of Health and Senior Services
AVIAN INFLUENZA SCREENING INFORMATION**

Instructions: Fax completed form to: _____

For NJDHSS Use Only
Date: ____/____/____
Reviewer: _____

REPORTING INFORMATION

E-#: _____ CDRSS #: _____ PHEL Specimen#: _____	Reported By: Name: _____ Agency: _____ Contact Number: _____
---	---

PATIENT INFORMATION

Last Name: _____ First: _____ Address: _____ City: _____ State: _____ County: _____ Municipality: _____ Date of Birth: ____/____/____ Age: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Occupation: _____	Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other/Unknown Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
---	---

CLINICAL INFORMATION

Was the patient evaluated by a healthcare provider?
 Yes No Unknown If Yes, provide the following information:
 Provider Name: _____
 Address: _____ City: _____ State: _____
 Primary Phone No.: _____ Secondary Phone No.: _____

During the course of illness, was patient hospitalized?
 Yes No Unknown
 If Yes, Name of Hospital: _____
 Was patient in ICU? Yes No Unknown
 Was the patient intubated? Yes No Unknown

SIGNS AND SYMPTOMS				CLINICAL FINDINGS			
YES	NO	UNKNOWN		YES	NO	UNKNOWN	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever >100.4° F (>38° C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiographically confirmed pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Onset Date: ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acute respiratory distress syndrome (ARDS)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were fever reducing drugs taken prior to temperature reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Illness (please describe): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feverish (temperature not taken)	_____			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough	_____			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	_____			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	_____			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Conjunctivitis	_____			

LABORATORY TESTING

Was Rapid Antigen Test performed for influenza?
 Yes No Unknown If Yes, date specimen collected: ____/____/____
Result: Influenza A Influenza B Influenza (type not specified) Negative Pending

RISK FACTORS

In 10 days prior to symptom onset:

YES	NO	UNKNOWN	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did patient travel to a country with documented animal or human cases of Avian Influenza*?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did patient have direct contact with domestic poultry (e.g., touching sick or dead chickens or ducks or well appearing ducks)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did patient consume uncooked poultry or poultry products?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did patient have direct contact with surfaces contaminated with poultry feces?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did patient have close contact (within 3 feet) of a known or suspected human case of H5N1?

*<http://www.cdc.gov/flu/avian/outbreaks/current.htm>