



Novel Virus (Swine) / Pandemic Influenza

Isolation and Quarantine/Antiviral Form

Date: _____ Interviewer: _____ Face to face Telephone

Person Interviewed: _____ Relationship to Patient: _____

Section A: Patient Information

Last Name(s): _____ First Name: _____ MI: _____

DOB: _____ Age: _____ Years Months Days

Address: _____

City: _____ ZIP: _____ County: _____

Phones: (H) _____ (W) _____ (C) _____

Emergency Contact: Name: _____ Relationship: _____

Contact's Phones: _____

Healthcare provider: _____ Phone: _____

Does patient work in a healthcare facility? Yes No

Demographics	
Race(s):	
<input type="checkbox"/>	Am Ind./Alaska Native
<input type="checkbox"/>	Asian
<input type="checkbox"/>	Native Hawaiian/Pac. Isl.
<input type="checkbox"/>	White
<input type="checkbox"/>	Black
<input type="checkbox"/>	Multiracial
Ethnicity:	
<input type="checkbox"/>	Hispanic
<input type="checkbox"/>	Non-Hispanic
Gender:	
<input type="checkbox"/>	Male
<input type="checkbox"/>	Female

Section B: Clinical Screening for Novel Virus (Influenza-like illness or ILI) / Risk Factor Review

Pt. Current Location: Hospital / ER Home Institution: _____ Other: _____

Status: Currently Ill Not Ill Contact Deceased Date of Death: ____ / ____ / ____

Date of Symptom Onset: ____ / ____ / ____

Fever >100 F / ≥37.8 C Yes No Feverish (not measured) Max Fever ____ Fever Onset : ____ / ____ / ____

Symptoms present: **Sore throat** **Cough (ILI is Fever >100 F plus sore throat/cough w/o other known cause)**

Rhinorrhea Conjunctivitis Diarrhea Vomiting

Fatigue Chills Seizures Headache / Body ache

Severe Respiratory Sx: SOB Sputum Mechanical Ventilation Other: _____

Chest X-ray If yes, Normal Abnormal Unknown

Chest CT scan If yes, Normal Abnormal Unknown

If X-ray or CT scan abnormal, evidence of: ARDS Pneumonia Severe respiratory illness with no alternate diagnosis

Hospitalized: Yes No Unknown Hosp Admission Date ____ / ____ / ____

ICU: Yes No Unknown Hosp Discharge Date: ____ / ____ / ____

Complicating / Risk Factors (check if present)

Pregnant Yes, _____ Weeks No

Asthma Other chronic lung disease Chronic health or circulatory condition Metabolic disease including diabetes mellitus

Kidney disease Cancer in last 12 mos Neurological disease

Immunosuppressive condition (HIV, Chronic corticosteroid therapy, organ transplant recipient)

Other chronic disease _____

Name: _____ DOB: _____ Other ID: _____

Diagnostic Findings:

Leukopenia (white blood cell count < 5,000 leukocytes/mm3) Yes No Unknown

Lymphopenia (total lymphocytes <800/mm3 or lymphocytes <15% of total WBC) Yes No Unknown

Thrombocytopenia (total platelets <150,000/mm3) Yes No Unknown

Comments: _____

Section C: Influenza Immunization

Immunized against human influenza in the past year? Yes No Unknown Date: ____/____/____

Type of Immunization: Inactivated (shot) Live attenuated (nasal spray) Unknown

Section D: Epidemiological / Travel / Contact Risk Screening for Novel Virus

1. **Travel** to a community either within the United States or internationally where there are one or more confirmed swine influenza A (H1N1) cases within 7 days of symptom onset? Yes No Unknown

(See list of affected US states here: <http://www.cdc.gov/swineflu/>; affected countries, from WHO: <http://www.who.int/csr/don/en/>)

• Mode of transportation Car Plane Airline _____ Flight # _____ Bus Other _____

• Travel group (family/school/tour group, etc.) _____

• Date of return to the US/home: ____/____/____

2. **Close contact** (≤ 6 feet) within the past 7 days to an ill person who is confirmed, probable, or suspected case of swine influenza A(H1N1) virus infection during the case’s infectious period (Day -1 to 7 from onset of illness): Yes No Unknown

3. **If yes to #2**, into which contact category(ies) does the patient fit?

Household Work/School Healthcare worker First Responder Other: _____

4. Has patient had family members or close contacts with pneumonia or influenza-like illness? Yes No Unknown

5. Other Close Contact

Handled samples (animal or human) suspected of containing influenza virus (A, H1N1) in a laboratory or other setting?

Other, specify: _____

Comments: _____

Section E: Next Steps for (+) Clinical or Travel Risk Screenings for Novel Virus

Check if Section E Skipped (currently in WHO Pandemic Phase 6 or not tested due to being part of a cluster of illness)

If patient has (+) clinical findings in Section B and at least one Epidemiological / Travel / Contact Risk Factor (#’s 1-2, 4-5) in Section D within 7 days prior to symptom onset, consider Lab Testing.

Refer to www.scdhec.gov/health/disease/han/notifications.htm for most recent testing guidelines, priorities.

Collection date (mm/dd/yy): _____ **State Lab Specimen ID:** _____

Test	Specimen type	Results
<input type="checkbox"/> Nasopharyngeal Swab for RT-PCR		
<input type="checkbox"/> Nasopharyngeal Swab for Viral Culture		
<input type="checkbox"/> Rapid Antigen Test		
<input type="checkbox"/> Other:		

Name: _____ DOB: _____ Other ID: _____

Specimens sent to CDC (if applicable):			
Date	Specimen Type	State Lab Specimen ID	Results

Section F: If Hospitalized, Patient location information NA

Hospital/Room/Wing: _____

Patient is currently located in an appropriate isolation room? Yes No Unknown

Hospital Point of Contact: _____ Contact Phone #: _____

Attending Physician and Contact Info: _____

Section G: Hospital/Clinic Personnel information NA

List healthcare personnel names and titles involved with patients' admission, treatment, and assessment:

Name	Title	Phone #	Nature of Contact

Append additional sheets as necessary.

Section H: Exposure Information

Contacts: Number of household members including the case patient. _____

List persons with whom patient has had close contact during infectious period (1 day prior to onset of symptoms to Day 7 of symptoms). Include contact info for potentially exposed persons. Append additional sheets as necessary.

Name	Relationship	Phone #s	Nature of Contact	Feverish	Max temp >100	Cough	Sore throat	Runny nose	Diarrhea	Onset date
				<input type="checkbox"/>						
				<input type="checkbox"/>						
				<input type="checkbox"/>						
				<input type="checkbox"/>						
				<input type="checkbox"/>						
				<input type="checkbox"/>						
				<input type="checkbox"/>						
				<input type="checkbox"/>						
				<input type="checkbox"/>						
				<input type="checkbox"/>						

Name: _____ DOB: _____ Other ID: _____

DHEC USE ONLY: Treatments and Public Health Disease Control Measures used by DHEC.

Section I: Isolation / Quarantine Measures NA

- 1. Voluntary Isolation Voluntary Quarantine Mandatory Isolation Mandatory Quarantine Not indicated
- 2. Location _____ Start Date/Time _____ End Date/Time _____
- 3. Contact information if different from above _____
- 4. Close household contacts subject to quarantine _____
- 5. Suspect /probable/confirmed cases and their contacts advised to remain at home: Yes NA
- 6. Isolation and quarantine forms given to case? Yes, Voluntary Yes, Mandatory Form Date: _____ NA

Section J: Novel Virus / Pandemic Influenza Antiviral Therapies

Antiviral Use Strategy Recommended: Treatment Post-Exposure Prophylaxis None

If antivirals not given / recommended, reason: _____

Section K: Antivirals / Pharmaceuticals **Treatment to be based on most recent DHEC SO for Antivirals**

Screened for precautions / contraindications: Check any which apply. Pregnancy Drug Allergies Renal disease

Date of DHEC SO for Antivirals: _____

<input type="checkbox"/> Oseteltamivir (Tamiflu) Check regimen prescribed/dispensed	Prescribed	Dispensed	Quantity
<input type="checkbox"/> Oseteltamivir (Tamiflu) 75 mg caps BID x 5 days Treatment	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Oseteltamivir (Tamiflu) 45 mg caps BID x 5 days Treatment	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Oseteltamivir (Tamiflu) 30 mg caps BID x 5 days Treatment	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Oseteltamivir (Tamiflu) 75 mg caps BID x 10 days Prophylaxis	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Oseteltamivir (Tamiflu) 45 mg caps BID x 10 days Prophylaxis	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Oseteltamivir (Tamiflu) 30 mg caps BID x 10 days Prophylaxis	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Oseteltamivir (Tamiflu) 12 mg/ml suspension (25 ml when reconstituted)	<input type="checkbox"/>	<input type="checkbox"/>	
Strength	Dose	Frequency	Quantity Disp.
			Lot Number
			Exp. Date

Zanamivir (Relenza) **Treatment: 2 5 mg rotadisks for inhalation bid x 5 days** or **PEP 2 5 mg qday x 10 days**
 Prescribed Dispensed **Quantity:** _____

Other: _____

Patient Drug & Adverse Reaction Instructions Given? Yes No Drug fact sheet given by _____

Additional Instructions to Patient: _____

Signature: _____ **Date:** _____

Section L: Adverse Reaction

Adverse Reaction Reported (Date) _____ by whom? _____ ACTION: _____

Status at the time of the report: See http://www.cdc.gov/swineflu/casedef_swineflu.htm for case definitions.

Confirmed Probable Suspect Contact to a confirmed or probable case _____

Submitted by: _____ **Date submitted to DHEC:** _____

If capacity exists, save this file as a PDF document, Email to DADE-OC@dhec.sc.gov. Otherwise, this form is to be faxed to the SC DHEC Division of Acute Disease Epidemiology, 803-898-0897.