

Hospitalized Influenza Like-Illness (ILI) Reporting Form

INSTRUCTIONS: Please complete as much of this form as you are able to within 24 hours of admission and fax to: Surveillance Unit, MHL Public Health at (204) 948-3044, or; phone with a verbal report to 788-6481

SCREENING QUESTION: Patient must have both of the following:

- Recent or current** history of Influenza-Like Illness (Acute onset of respiratory illness with a history of fever and cough and one or more of: sore throat, arthralgia, myalgia or prostration) and/or other variations of symptoms and signs consistent with a clinical diagnosis of influenza-like illness. See Clinical Care Guidelines for other manifestations.
- be ill enough to require hospitalization.

PATIENT INFORMATION

Last name: _____ First name: _____

PHIN: _____ MH #: _____

Date of Birth (yyyy/mm/dd): ____/____/____ Sex: Male Female Don't Know

Occupation: _____

Usual address (check if patient is homeless or not fixed address)

Street: _____ City/Town: _____

Province/Territory: _____ Postal code: _____

Date of onset of symptoms? (yyyy/mm/dd): ____/____/____

When was the patient first seen by a primary care clinician for this illness? (yyyy/mm/dd): ____/____/____

Name of clinician and/or clinic: _____

Did the patient receive antivirals: No Yes If yes when: (yyyy/mm/dd): ____/____/____

Did patient receive this year's seasonal influenza vaccine (Oct/09-Apr/10)? No Yes If yes when: _____

Did patient receive this year's pandemic H1N1 vaccine (Oct/09-Apr/10)? No Yes If yes when: _____

Pre-existing conditions/risk factors (check all that apply):

Ethnicity: Aboriginal No Yes If yes: First Nation Métis Inuit

Pregnant Yes No

Does the patient have pre-existing chronic conditions Yes No (See Clinical Care Guidelines for list)

Immunodeficiency or on immunosuppressing medications Yes No

Behavioural risk factors (e.g. smoking, other substance abuse) Yes No

Other risk conditions (e.g. homeless, refugee, recent immigrant, poverty etc) Yes No

HOSPITAL INFORMATION

Hospital Name: _____ Date admitted (yyyy/mm/dd): ____/____/____

Diagnosis at time of admission _____

Admitted to ICU? No Yes If yes, date (yyyy/mm/dd): ____/____/____

Ever mechanically ventilated? No Yes

REPORT STATUS

Person Completing Form: _____ Contact Phone Number: _____

Date Form Completed: (yyyy/mm/dd): ____/____/____

NOTE: This completed form can be attached to the Confirmed/Probable Pandemic H1N1 Case Report form to minimize re-entering previously reported information