

**REPUBLIC OF LEBANON**  
Ministry of Public Health

Case Investigation form  
Novel Influenza

Investigator:
Investigation date:

## 1. Reporting details

Name	Date of report	Institution	Telephone

## 2. Patient identity

Name	Sex	Date of Birth	Nationality
	<input type="checkbox"/> male <input type="checkbox"/> female		
Full address	Caza/Locality	Telephone	

## 3. Signs and symptoms

Date of onset of illness	Body temperature $\geq 38^{\circ}\text{C}$	Cough	Sore throat	Shortness of breath
	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no

4. History of admission to hospital. Admission to hospital? yes no

If yes,	Name of hospital	Caza	Date of admission	Patient isolated or cohorted?	Date of isolation/ cohorted	Admitted to ICU?	Mechanical ventilation?	Date of discharge
Hospital1				<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	
Hospital2				<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	
Hospital3				<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	
Hospital4				<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	

## 5. Travel history.

During the 7 days prior to the onset of symptoms, did the person travel or reside abroad? yes no

Place				Primary means of transport	Risk			
Country	City	Date of departure	Date of departure		Novel influenza in humans reported	Novel influenza in animals reported	Contact with human cases	Contact with animals/ birds
				<input type="checkbox"/> plane <input type="checkbox"/> boat <input type="checkbox"/> road			<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
				<input type="checkbox"/> plane <input type="checkbox"/> boat <input type="checkbox"/> road			<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
				<input type="checkbox"/> plane <input type="checkbox"/> boat <input type="checkbox"/> road			<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
				<input type="checkbox"/> plane <input type="checkbox"/> boat <input type="checkbox"/> road			<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no

## 6. Occupational exposure. During the 7 days prior symptoms onset, has the person been working:

If yes, specify institution:

In animal-related occupation? (farm/plant worker, chef working with live or recently killed domestic fowls, dealer/trader of pet birds)?	<input type="checkbox"/> yes <input type="checkbox"/> no	
As a worker in laboratory where samples are tested for influenza?	<input type="checkbox"/> yes <input type="checkbox"/> no	o
As a health care worker?	<input type="checkbox"/> yes <input type="checkbox"/> no	

## 7. History of exposure to animal populations. During the 7 days prior to symptoms onset, has the person:

	Contact within 1 meter with any live or dead animal of species listed?	Entered settings where animal species were confined or had been confined in the previous 6 weeks	In yes, list countries and regions where these exposures occurred:
Domestic fowl (birds commonly reared for flesh, eggs, feathers, including chickens, ducks, geese, turkeys, guinea-fowls)	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	
Wild birds	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	
Swine	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	
Horses	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	

## 8. History of exposure to human cases. During the 7 days prior to the onset of symptoms, has the person been in contact (within touching or speaking distance) with:

	Yes/No	If yes, specify Influenza subtype	If yes, specify patient name
A confirmed human case of novel influenza A infection?	<input type="checkbox"/> yes <input type="checkbox"/> no		
A death from an unexplained acute respiratory illness?	<input type="checkbox"/> yes <input type="checkbox"/> no		
Any person suspected to have novel influenza A infection?	<input type="checkbox"/> yes <input type="checkbox"/> no		
Any cluster of severe acute respiratory infection?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, specify setting: <input type="checkbox"/> household <input type="checkbox"/> extended family	<input type="checkbox"/> hospital <input type="checkbox"/> residential institution <input type="checkbox"/> military barracks <input type="checkbox"/> recreational camps <input type="checkbox"/> other, specify

## 9. Laboratory investigation results for influenza A/H5

#	Type of specimen <sup>1</sup>	Date of collection	Test <sup>2</sup>	Laboratory	Result	Date of result	Subtypes

<sup>(1)</sup> Specimens: nasopharyngeal swab, oropharyngeal swab, nasal wash, tracheal aspirate, bronchoalveolar lavage, serum, paired sera...<sup>(2)</sup> Tests: rapid test, single serology, paired serology, IFA, PCR, virus culture, Virus subtyping

## 10. Prophylaxis against influenza

	Yes/No	If yes, specify
6 months prior to symptoms onset: Influenza vaccine?	<input type="checkbox"/> yes <input type="checkbox"/> no	Vaccine name: Country of administration:
7 days prior to symptoms onset: antiviral treatment	<input type="checkbox"/> yes <input type="checkbox"/> no	Drug name: Taken regularly:

## 11. Final disposition &amp; classification

Date	Clinical status	Classification
	<input type="checkbox"/> recovered <input type="checkbox"/> deceased, date: <input type="checkbox"/> lost to follow-up	<input type="checkbox"/> confirmed <input type="checkbox"/> probable <input type="checkbox"/> possible <input type="checkbox"/> discarded