VPD-7b
Revised July 2017

Influenza, Supplemental Investigation Questions

Patient Name: DOB: ___/___/___ VPD-7a completed? ☐ Yes ☐ No

Supplemental form is for use with the General Influenza Investigation Form (VPD-7a). Sections on this supplemental form can be completed as needed.

BASIC TRAVEL HISTORY

Did the case travel in the 10 days prior to illness onset? ☐ Yes, within state ☐ Yes, out of state ☐ Yes, out of country ☐ No ☐ Unknown

If yes,

Traveled to:_____ Dates of travel: ____/____/____ to ____/____/____

Traveled to:_____ Dates of travel: ____/____/____ to ____/____/____

Traveled to:_____ Dates of travel: ____/____/____ to ____/____/____

Did any close contacts of the patient travel in the month prior to patient's illness onset? ☐ Yes ☐ No ☐ Unknown

If yes,

Name:_____ Relation to case: _____ Traveled to:_____ Dates of travel:____/____/____to____/____/___

Name:_____ Relation to case: _____ Traveled to:_____ Dates of travel: ____/____/____to____/____/__

EXTENSIVE TRAVEL HISTORY (for investigations requiring contact tracing)

If case travel involved an airline, please provide the following for all flights in the 10 days prior to onset through 24 hours after symptoms end:

Departure date ____/____/____ Departure time:_____ From:_____ To: _____ Airline:_____ Flight number:_____
Departure date ____/____/____ Departure time:_____ From:_____ To: _____ Airline:_____ Flight number:_____
Departure date ____/____/____ Departure time:_____ From:_____ To: _____ Airline:_____ Flight number:_____
Departure date ____/____/____ Departure time:_____ From:_____ To: _____ Airline:_____ Flight number:_____

If case travel involved a bus, please provide the following for all trips in the 10 days prior to onset through 24 hours after symptoms end:

Departure date ____/____/____ Departure time:_____ From:_____ To: _____ Bus line:_____ Bus number:_____
Departure date ____/____/____ Departure time:_____ From:_____ To: _____ Bus line:_____ Bus number:_____

If case travel involved a cruise line, please provide the following for all trips in the 10 days prior to onset through 24 hours after symptoms end:

Cruise line:_____ Ship:_____ Departure date ____/____/___ Departure time:_____ Return date ____/____/___
Departure city:_____ Stops: _____

CLOSE CONTACTS

How many people live in the patient's household (including the patient)? _____ How many were/are sick? _____

Did the patient care for anyone who was sick (10 days before, concurrently or after)? ☐ Yes ☐ No ☐ Unknown

If yes,

Name:_____ Relation to case:_____ Date of onset: ____/____/____ Symptoms:_____

Or, if the case is a health care worker, where do they work:_____ Date last worked before onset: ____/____/____

Did any other close contacts of the patient have symptoms (sx) of illness (10 days before, concurrently or after)? ☐ Yes ☐ No ☐ Unk

If yes,

Name:_____ Age:____ Relation to case:_____ Date of onset: ____/____/____ Sx:_____
Name:_____ Age:____ Relation to case:_____ Date of onset: ____/____/____ Sx:_____
Name:_____ Age:____ Relation to case:_____ Date of onset: ____/____/____ Sx:_____
Name:_____ Age:____ Relation to case:_____ Date of onset: ____/____/____ Sx:_____

If you need to follow up with contacts, use the contact tracking form to collect additional information.

EXTRACURRICULAR ACTIVITIES

Does the patient participate in any extracurricular group activities (e.g., sports team, social club, etc) ☐ Yes ☐ No ☐ Unknown

If yes, type of activity/organization:_____ Name of organization/team:_____

Date last participated: ____/____/____ Number of people on team/at meeting:_____

Contact name:_____ Phone (___) _____-_____

SCHOOL / DAYCARE EXPOSURES

Does the patient attend school and / or a day care? ☐ Yes ☐ No ☐ Unknown

If yes, please check all at apply

☐ Grade school Grade:_____ Name of school:_____ Contact name:_____

Address: _____ City:_____ Phone (___) _____-_____

☐ University Name of school:_____ Contact name:_____

Address: _____ City:_____ Phone (___) _____-_____

☐ Day care Name of day care:_____ Contact name:_____

Address: _____ City:_____ Phone (___) _____-_____

☐ Other after school care Name of facility/program:_____ Contact name:_____

Address: _____ City:_____ Phone (___) _____-_____

Has the school or daycare seen an increase in ILI or other respiratory symptoms among attendees or staff? ☐ Yes ☐ No ☐ Unknown

ANIMAL EXPOSURES

Did the patient have any contact (touching or close proximity) with wild or domestic animals within the last month (check all that apply)?

☐ Chickens ☐ Ducks ☐ Pigs (swine) ☐ Turkeys ☐ Other:_____

If yes, please describe the contact (when/where/extent)_____

_____

_____

Did the patient visit any of the following locations where animals may be present within the last month (check all that apply)?

☐ Farm ☐ Petting zoo ☐ Agricultural event ☐ Rodeo ☐ Live animal market ☐ Slaughterhouse ☐ Pet store

☐ Other: _____

If yes, describe:_____

Was the patient exposed to environments contaminated by animal feces (including poultry, wild birds or swine) within the last month?

☐ Yes ☐ No ☐ Unknown

If yes, describe:_____

Did the patient touch (handle, slaughter, butcher, prepare for consumption) animals (including poultry, wild birds or swine) or their remains within the last month?

☐ Yes ☐ No ☐ Unknown

If yes, describe:_____

Did the patient consume raw or undercooked animals (including poultry, wild birds or swine) within the last month?

☐ Yes ☐ No ☐ Unknown

If yes, describe:_____

Are any sick or dead animal(s) present in the patient's home, neighborhood or workplace?

☐ Yes ☐ No ☐ Unknown

If yes, describe:_____

OTHER EXPOSURES

Did the patient handle specimens/samples (animal or human) suspected of containing influenza virus in a laboratory or other setting?

☐ Yes ☐ No ☐ Unknown

If yes, please describe:_____

LONG TERM CARE FACILITY EXPOSURES

Does the patient live or stay at a long term care facility? ☐ Yes ☐ No ☐ Unknown

If yes, name of facility: _____ Is anyone else at the facility symptomatic? ☐ Yes ☐ No ☐ Unknown

Contact name:_____ Phone (___) _____-_____

ADDITIONAL CLINICAL AND LABORATORY FINDINGS

Is the patient on chronic drug therapy? ☐ Yes ☐ No ☐ Unknown If yes, what: _____ dose/frequency:_____

Did the patient have leukopenia (WBC count < 5,000 leukocytes/mm3)? ☐ Yes ☐ No ☐ Unknown

Did the patient have lymphopenia (total lymphocytes <800mm3 or lymphocytes <15% of total WBC)? ☐ Yes ☐ No ☐ Unknown

Did the patient have thrombocytopenia (total platelets <150,000/mm3)? ☐ Yes ☐ No ☐ Unknown

Did the patient have hemoptysis? ☐ Yes ☐ No ☐ Unknown

Did patient have pulmonary/respiratory tract hemorrhage or hemorrhagic pneumonitis? ☐ Yes ☐ No ☐ Unknown

Did the patient have a chest X-ray or CT scan performed? ☐ Yes ☐ No ☐ Unknown
Findings: ☐ Normal ☐ Evidence of pneumonia ☐ Other:_____

Did the patient have a CT scan/MRI of the head or brain? ☐ Yes ☐ No ☐ Unknown
Findings: ☐ Normal ☐ Evidence of acute neurologic abnormality ☐ Other:_____

Did the patient require mechanical ventilation? ☐ Yes ☐ No ☐ Unknown

PREGNANCY / POSTPARTUM INFORMATION

Was the pregnancy considered high risk? ☐ Yes ☐ No ☐ Unknown

Did the mother have any of the following (Check all that apply)?
☐ Hypo or hyperthyroidism ☐ Gestational diabetes ☐ Obesity prior to pregnancy ☐ Gestational hypertension/preeclampsia/Eclampsia
☐ Tobacco use during pregnancy ☐ Hepatic disorder ☐ Substance abuse during pregnancy (e.g. alcohol / illicit drug use) ☐ Psychiatric disorder

If the patient was admitted to the ICU, how many days were spent in the ICU: _____ ☐ Still in ICU ☐ Unknown

Was the patient given any of the following medications during hospitalization (Check all that apply)?
☐ Antibiotics ☐ Antihypertensives ☐ Vasopressors ☐ Systemic corticosteroids (if checked was it for the mother's health or the infant's)
☐ Nebulized drugs ☐ Antiepileptics ☐ Antiglycemics ☐ Tocolytic agents ☐ Diuretics ☐ Narcotic Analgesic ☐ Sedative / Hypnotic
☐ Antifungal ☐ Other:_____ ☐ None ☐ Unknown

What is/was the estimated due date? ____/____/____ **Date of delivery:** ____/____/____

Where did delivery occur:
☐ Labor and delivery department ☐ Emergency department ☐ Intensive care unit ☐ Home ☐ Other_____ ☐ Unknown

What was the method of delivery:
☐ Still pregnant ☐ Vaginal ☐ Cesarean, scheduled ☐ Cesarean, emergency ☐ Cesarean, unknown if scheduled/emergency ☐ Unknown

Was this a multiple fetus pregnancy (e.g. twins, triplets)? ☐ Yes, number_____ ☐ No ☐ Unknown (if yes, please provide info on each infant)

What was the infant's outcome? ☐ Survived ☐ Stillbirth ☐ Spontaneous abortion ☐ Died within 8 weeks of birth ☐ Unknown

What was the gestational age (weeks) at delivery? _____ ☐ Unknown

What was the infant's birth weight? _____ ☐ Unknown

Did the infant have any of the following during hospitalization (Check all that apply)?
☐ Rash ☐ Fever ☐ Temperature instability ☐ Bradycardia ☐ Apnea ☐ Petechiae ☐ Chorioretinitis ☐ Cataracts ☐ Seizures
☐ Meningitis ☐ Other neurologic abnormality, specify_____ ☐ Hearing loss ☐ Pneumonia ☐ Sepsis
☐ Respiratory distress, specify cause_____ ☐ Hypoglycemia ☐ Hyperbilirubinemia/Jaundice
☐ Other _____ ☐ Other _____

Was the infant diagnosed with influenza? ☐ Yes ☐ No ☐ Unknown

Did the infant have any influenza tests done? ☐ Yes ☐ No ☐ Unknown
If yes, test[1] _____ result[1]_____; test[2] _____ result[2]_____

NOTES

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