# DoD Global Influenza Surveillance Program

## Swine Influenza Surveillance Questionnaire

**Installation:** _____ Date of Clinic Visit:_____-_____-_____
DD-MMM-YYYY

*PRIVACY ACT STATEMENT: The social security number is required to facilitate documentation of health care received and patient follow-up. The primary use of this information is to aid in preventive health and communicable disease control programs. The requested information is voluntary.*

**Patient Information** **PLEASE PRINT LEGIBLY**

Patient Name:_____ Date of Birth: ____ -_____ - _____
Last Name, First Name DD-MMM-YYYY

Patient FMP/Sponsor SSN ____ / __ __ __ - __ __ - __ __ __ __ Gender: Male / Female
FMP Sponsor SSN

Sponsor's (military member) Work Phone (_____)_____-_____DSN #_____-_____

If taken at home, Highest Temp Recorded:_____ Date Taken_____-_____-_____
DD-MMM-YYYY

**Symptoms:** *Please select NA (Not Applicable) if the presence of symptoms cannot be determined.*

| | | |
|---|---|---|
| *Sore Throat:* Yes / No / NA | *Cough:* Yes / No / NA | *Vomiting:* Yes / No / NA |
| *Chest Pain:* Yes / No / NA | *Fatigue:* Yes / No / NA | *Conjunctivitis:* Yes / No / NA |
| *Headache:* Yes / No / NA | *Chills:* Yes / No / NA | *Ear Ache:* Yes / No / NA |
| *Diarrhea:* Yes / No / NA | *Body Aches:* Yes / No / NA | *Stiffness:* Yes / No / NA |
| *Dyspnea:* Yes / No / NA | *Runny Nose:* Yes / No / NA | *Sinus Congestion:* Yes / No / NA |

Did the patient travel recently (past 14 days)? Yes No Unknown

If YES, Where?_____ When?_____
City, State/Province, Country

Has the patient received the influenza vaccine this season? Yes No Unknown

If YES, list date _____ Estimated Date: _____ & _____
DD-MMM-YYYY Month 1st half or 2nd half of Mo.

Type: ____Injection (Flu Shot) ____Nasal Spray (FluMist)

Location: ____Military facility ____Civilian facility

**Clinical Information** **PRINT LEGIBLY**

Fever (≥ 100.0 °F oral or equivalent) **Temp =** _____ **Subjective Temp =** _____

*AND* (check the symptom/s) a. ____Cough or b. ____Sore throat (<72 hours duration)

When did symptoms start? Date:_____ - _____ - _____
DD-MMM-YYYY

Hospitalized? Yes / No If YES, how long (hrs)?_____ Hospital Name? _____

Patient put on Quarters? Yes / No If YES, how long (hrs)?_____

Physician (name and number): _____
Name Contact Phone Number

**ILI Case Definition**

**- Fever > 100.0 F (37.8 C) oral or equivalent**
**and**
**- Cough and/ or Sore Throat and/ or Runny Nose**

**Question?**
**Please contact:**
**nhrc-fri@med.navy.mil**
**Phone 619-553-9105**

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# CASE REPORT FORM

## Active Surveillance for Respiratory Pathogens

## Individual Case

Specimens and available clinical data should be obtained from each participant.

Clinic Address: _____

Point of Contact: _____

Patient Last Name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

First Initial: [ ]

Social Security Number: [ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

Age: [ ][ ][ ] ○ Years ○ Months

Barcode Label or Subject ID: [ ]

Date Collected (MM/DD/YYYY): [ ][ ] / [ ][ ] / 2 0 [ ][ ]

Gender: ○ Male ○ Female

Patient Status: ○ Inpatient ○ Outpatient

Highest oral temperature: [ ][ ][ ] . [ ] °F

No. of days since symptoms began: [ ][ ] days

### Patient History:

Is the patient deceased? ○ Yes ○ No

Rapid test performed? ○ Yes ○ No

Result? ○ A ○ B ○ Negative

Recent travel? ○ Yes ○ No ○ Unknown

If yes, date: [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

place: _____

Is the patient at high risk for avian influenza? ○ Yes ○ No

If answered yes, please complete avian influenza risk assessment.

Has the patient received an influenza vaccine within the last 12 months?

○ Yes ○ No ○ Unknown

If yes, date: [ ][ ] / [ ][ ] / [ ][ ][ ][ ]
mm dd yyyy

type: ○ FluMist ○ Injection

**SPECIMEN EVALUATION (FOR NHRC USE ONLY)**

Fresh? ○ Yes ○ No ○ N/A

Frozen? ○ Yes ○ No ○ N/A

Label information matches CRF? ○ Yes ○ No

Leaks? ○ Yes ○ No

Other? ○ Broken
○ Missing
○ No swab

Specimen Acceptability:
○ Acceptable for culture
○ Acceptable with disclaimer
○ Rejected, specify reason

**Department of Respiratory Diseases Research**
**Naval Health Research Center**
140 Sylvester Road● San Diego, CA 92106 ● Tel (619) 553-9105
Fax (619) 553-7601 ● email: nhrc-fri@med.navy.mil

## Diagnostic Specimen Shipping Instructions

1. Package specimen according to appendix1 (Shipping SOP).

2. All shipments must include four basic requirements:
   - watertight primary containers
   - absorbent material
   - watertight secondary containers
   - sturdy outer packaging

3. Upon request, shipping materials are available from NHRC.

4. A lab requisition form and a specimen log must be included in your specimen shipment.

5. When choosing a courier to ship, use the following guidelines:
   - Shipped in CONUS – use FedEx
   - Shipped OCONUS – use World Courier

6. The outside of all packages must have the following information:
   - Label UN1845 - dry ice (indicating the number of kilograms of dry ice in the package)
   - Label UN3373 – Biological Substance Class B (both must be present)

7. All packages should be shipped to the following address:

   Naval Health Research Center
   McClelland Rd. and Patterson Rd.
   Gate 4, Building 315
   ATTN: Laboratory
   San Diego, CA 92152

For any questions please contact us at:
nhrc-fri@med.navy.mil
Phone (619) 553-9105

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**Laboratory Request**
Naval Health Research Center
Dept. of Respiratory Disease Research
McClelland & Patterson Rds. Gate 4
Building 315
San Diego, California 92152
Microbiology Section: 619-553-8771
Molecular Section: 619-553-0755

CAP# 6928701
CLIP# DOD9215201

**Laboratory Director:**

(Lab Use Only) Date Received:

Request ID:

**Study Name:**

**Site Information/ Site ID#:**
Name:
Address:

Point of Contact:

## SELECT TESTS BY CHECKING BOX

○ **Atypical Pneumonia Mulitplex PCR***
- *M. pneumoniae*
- *C. pneumoniae*
- *B. pertussis*
- *L. pneumophila*

**Coronavirus**
○ RT-PCR OC43, 229E & NL63*
○ SARS PCR by LightCycler*

○ **Respiratory Viral Culture Panel**
- Influenza A / Influenza B
- Adenovirus
- Parainfluenza 1, 2 & 3
- RSV
- Herpes Simplex 1 & 2
- Enterovirus

**Influenza**
○ Subtyping HAI
○ RT-PCR
○ RT-PCR by Light Cycler*
○ LRN H5
○ Molecular Typing*

**Adenovirus**
○ Culture Identification
○ Serotyping (microneutralization)*
○ PCR
○ PCR by Light Cycler*
○ Adenovirus - 36 Serology*
○ Adenovirus - 4 & 7 Serology*
○ Multiplex PCR for Adenovirus Typing (Specify)

**Human Metapneumovirus**
○ RT-PCR*

○ **Bacteriology Culture***

***B. pertussis***
○ Culture Identification
○ PCR*

***C. pneumoniae***
○ Serology IgM and IgG*
○ PCR*

***M. catarrhalis***
○ PCR*

***M. pneumoniae***
○ Culture Identification
○ Serology IgM and IgG
○ PCR*

***N. meningitidis***
○ PCR*
○ Culture Identification
○ Antibiotic Sensitivity Test (E-Test)
○ Serogrouping

***H. influenzae***
○ Culture Identification
○ Antibiotic Sensitivity Test (E-test)
○ PCR*

***S. aureus***
○ Culture Identification
○ Antibiotic Sensitivity Test

***S. pneumoniae***
○ Culture Identification
○ Antibiotic Sensitivity Test
○ Serotyping*
○ Pneumococcal pneumolysin PCR*
○ PCR*

***S. pyogenes***
○ Culture Identification
○ Antibiotic Sensitivity Test
○ Emm Typing*
○ Spe B PCR*
○ Serogrouping

**Misc.**
○ Enterovirus PCR*
○ RSV PCR*
○ Rhinovirus RT-PCR*
○ Storage Only

**Other (Specifiy Lab Section and Test)**
○ Microbiology ○ Molecular

**Number of Specimens**

*Record all specimen information on specimen log.*

Page 1 of

**Requesting Clinician or Designee (Print Name):**

**Sign Name:**

**Date:** MM / DD / YYYY

*** research only test**

Form: 4.40
Effective Date: 5/22/2006
Version: A2

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# Laboratory Specimen Log

**(For Office Use Only)**
Request ID:

**Instructions for Completing Specimen Log Form QA-4.50**
1. Specimen Logs must be accompanied with a laboratory requisition, form 4.40
2. Use one sheet per specimen/ media type.
3. For serum specimens, enter media type as "None".
4. Specimen collector's initials required for serum samples only.

Page ____ of ____

## Specimen Type

- ○ Quality Control/ Blank
- ○ Aspirate
- ○ Body Fluid
- ○ Body Tissue
- ○ Bronchial
- ○ Bronchial Wash
- ○ Cerebral Spinal Fluid
- ○ Homogenate
- ○ Isolate
- ○ ITCF
- ○ Other:_____
- ○ Lyophilized
- ○ Nasal/Throat Combination
- ○ Nasal Swab
- ○ Serum, Acute
- ○ Serum, Convalesent
- ○ Sputum
- ○ Stool
- ○ Throat Swab
- ○ Whole Blood

## Media Type

- ○ None
- ○ A549
- ○ RMK
- ○ Plate
- ○ Slant
- ○ SP4 Broth
- ○ TSB Buffer
- ○ TE Buffer
- ○ UTM
- ○ VTM
- ○ Unknown
- ○ Other:_____

| Date Collected MM / DD / YYYY | 1st Identifier | 2nd Identifier | Comments | Specimen collector initials |
|---|---|---|---|---|
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