SARI Case Investigation Form

Date of Reporting: _____ Region: _____ Parish: _____
Doctor: _____ Hospital/Site: _____ Ward: _____
Email: _____ Phone #: _____
Hospital/Medical Record Number: _____ NEW CASE ☐ UPDATE ☐
Admission Date: _____ Date of Onset of Illness: _____ Epidemiological Week of Onset: _____
Last Name: _____ First Name: _____
Date of Birth: _____ Age: _____ Sex: MALE ☐ FEMALE ☐
Country of Residence: _____ Parish: _____ Community: _____
Street #: _____ Street Name: _____

Sample taken: Yes ☐ No ☐ Sample Type: _____ Date Sample Taken: _____

Sample taken to Lab: Yes ☐ No ☐ Date sample taken to Lab: _____

Influenza Vaccine: Yes ☐ No ☐ Date of last vaccination: _____

CLINICAL AND EPIDEMIOLOGICAL PROFILE								
CLINICAL PROFILE								
History of Fever or Fever over 38°C (<10 days)				Yes	No	Recorded temperature _____ °C		
Cough	Yes	No	Otitis	Yes	No	Pneumonia	Yes	No
Rhinorrhea	Yes	No	Conjunctivitis	Yes	No	Adenopathea	Yes	No
Sore Throat	Yes	No	Headache	Yes	No	Vomiting	Yes	No
Shortness of Breath	Yes	No	Myalgia	Yes	No	Diarrhea	Yes	No
Difficulty Breathing	Yes	No	Bronchitis	Yes	No	Rash	Yes	No
Wheezing	Yes	No	Bronchiolitis	Yes	No			
RISK FACTORS								
Pregnancy If yes, Trimester	Yes	No	Lung Disease including COPD	Yes	No	Immunocompromised due to disease or treatment	Yes	No
	1 2 3		Asthma	Yes	No	HIV/AIDS	Yes	No
Diabetes Mellitus	Yes	No	Neurological Disease	Yes	No	Obesity	Yes	No
Sickle Cell Disease	Yes	No	Liver Disease	Yes	No	If Yes 30 – 40 ☐ Over 40 ☐ Unknown ☐		
Heart Disease	Yes	No	Renal Disease	Yes	No			
Children under 2 years:								
Prematurity			Yes	No	Malnutrition		Yes	No
Low Birthweight (LBW)			Yes	No	Lack of Breastfeeding		Yes	No
EPIDEMIOLOGICAL PROFILE								
Sporadic Case			Yes	No	Animal Contact If yes Home ☐ Swine ☐ Bird/Poultry ☐		Yes	No
Part of an Outbreak			Yes	No	Travel abroad in the past 6 weeks		Yes	No
Part of Cluster (3 or more persons geographically or socially linked with onset of disease within 10 days of each other)			Yes	No	If yes to travel, country(ies) visited: _____			
Other:								

Treatment Received (in hospital): Antiviral Yes ☐ No ☐ Type: _____ Date: _____

Antibiotics Yes ☐ No ☐ Types: _____ Date: _____

Laboratory Results: Virology Positive ☐ Negative ☐ Virus: _____

Bacteriological Positive ☐ Negative ☐ Bacteria: _____

Admitted to ICU: Yes ☐ No ☐ Date of admission to ICU: _____

Discharge Date: _____ SARI Death: Yes ☐ No ☐ Date of Death: _____

Final Diagnosis: _____ MO(H) Signature: _____