

Patient Summary Form for Suspect Avian Influenza A/H5 Infection

Patient Name: _____ Sex: M F

DOB _____ Age _____ County of Residence: _____
mm/dd/yyyy

Health Department: _____ LHD Contact Name: _____

LHD Phone: _____

Reporting Facility: _____ Physician: _____ Physician Phone: _____

Illness Onset Date: _____

Symptoms (check boxes): Fever Temperature _____ Headache Conjunctivitis
 Runny Nose Cough Congestion Diarrhea Myalgia Sore Throat

Other signs or symptoms: _____

Was Patient Hospitalized? Yes No ICU? Yes No

If Yes, Where _____ Admission Date: _____

Have Antivirals Been Given: Yes No If Yes, What Type: _____

Date Antivirals Started: _____ Dose given: _____

Was an Influenza Test Performed: Yes No Date of test: _____

Test Type: _____ Result: _____

Additional Testing to be Done at MDHHS: Yes No

If Yes, Specimen Collection Date: _____

Date Specimen Expected to Arrive at Bureau of Labs: _____

MDHHS BoL Micro-Virology Test Requisition Completed / Included: Yes No

Exposure Information: _____

Occupation: _____ Place of work: _____

Notes: _____

Please report any suspect cases immediately to MDHHS at (517) 335-8165 or (517) 335-9030 after hours or weekends. Fax completed form to (517) 335-8263.