

## Annex 4~D: Form for Active Daily Surveillance of Contacts of a Novel Influenza Virus

# Active Daily Surveillance of Contacts of a Novel Influenza Virus

CONFIDENTIAL

## CASE INFORMATION

Case Name

Case Unique Identification Number

(PI - NS - Health Card or Unique ID #) **PI-NS-**

Status of Case

- ILI  
 Laboratory-confirmed

## CONTACT INFORMATION

Contact Name

Date of birth (dd/mm/yyyy)      \_\_\_ / \_\_\_ / \_\_\_\_\_

Sex     Male     Female

HCN

Address

(City)                      (Prov)                      (Postal code)

Phone ( )

Name of family physician

Phone number of family physician ( )

Date of last contact with case (dd/mm/yyyy)      \_\_\_ / \_\_\_ / \_\_\_\_\_

Type of contact (e.g. HCW, household)

Contact is under (check all that apply)                       Self-monitoring  
 Active Daily Surveillance  
 Home Quarantine

Start date of surveillance (dd/mm/yyyy)      \_\_\_ / \_\_\_ / \_\_\_\_\_

Final date of surveillance (dd/mm/yyyy)      \_\_\_ / \_\_\_ / \_\_\_\_\_

Final assessment of contact                       Asymptomatic  
 ILI  
 Laboratory-confirmed case

## Active Daily Surveillance of Contacts of a Novel Influenza Virus

Name of Contact:				
Date of Surveillance	Symptoms		Daily Assessment (Check one)	
<b>Day 1</b> <b>Date (dd/mm/yyyy)</b>  ____ / ____ / ____	<b>Yes</b>	<b>No</b>	<input type="checkbox"/> Asymptomatic  <input type="checkbox"/> Symptomatic	
	<input type="checkbox"/>	<input type="checkbox"/>		Fever >38° C
	<input type="checkbox"/>	<input type="checkbox"/>		Rigor or chills
	<input type="checkbox"/>	<input type="checkbox"/>		Cough
	<input type="checkbox"/>	<input type="checkbox"/>		Shortness of breath
	<input type="checkbox"/>	<input type="checkbox"/>		Sore throat
	<input type="checkbox"/>	<input type="checkbox"/>		Arthralgia
	<input type="checkbox"/>	<input type="checkbox"/>		Myalgia
	<input type="checkbox"/>	<input type="checkbox"/>		Headache
	<input type="checkbox"/>	<input type="checkbox"/>		Vomiting
	<input type="checkbox"/>	<input type="checkbox"/>		Diarrhea
	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	
<b>Day 2</b> <b>Date (dd/mm/yyyy)</b>  ____ / ____ / ____	<b>Yes</b>	<b>No</b>	<input type="checkbox"/> Asymptomatic  <input type="checkbox"/> Symptomatic	
	<input type="checkbox"/>	<input type="checkbox"/>		Fever >38° C
	<input type="checkbox"/>	<input type="checkbox"/>		Rigor or chills
	<input type="checkbox"/>	<input type="checkbox"/>		Cough
	<input type="checkbox"/>	<input type="checkbox"/>		Shortness of breath
	<input type="checkbox"/>	<input type="checkbox"/>		Sore throat
	<input type="checkbox"/>	<input type="checkbox"/>		Arthralgia
	<input type="checkbox"/>	<input type="checkbox"/>		Myalgia
	<input type="checkbox"/>	<input type="checkbox"/>		Headache
	<input type="checkbox"/>	<input type="checkbox"/>		Vomiting
	<input type="checkbox"/>	<input type="checkbox"/>		Diarrhea
	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	

## Active Daily Surveillance of Contacts of a Novel Influenza Virus

Name of Contact:				
Date of Surveillance	Symptoms			Daily Assessment (Check one)
<b>Day 3</b> <b>Date (dd/mm/yyyy)</b>  ___ / ___ / _____	<b>Yes</b>	<b>No</b>		<input type="checkbox"/> Asymptomatic  <input type="checkbox"/> Symptomatic
	<input type="checkbox"/>	<input type="checkbox"/>	Fever >38° C	
	<input type="checkbox"/>	<input type="checkbox"/>	Rigor or chills	
	<input type="checkbox"/>	<input type="checkbox"/>	Cough	
	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	
	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	
	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	
	<input type="checkbox"/>	<input type="checkbox"/>	Myalgia	
	<input type="checkbox"/>	<input type="checkbox"/>	Headache	
	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	
	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	
<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
<b>Day 4</b> <b>Date (dd/mm/yyyy)</b>  ___ / ___ / _____	<b>Yes</b>	<b>No</b>		<input type="checkbox"/> Asymptomatic  <input type="checkbox"/> Symptomatic
	<input type="checkbox"/>	<input type="checkbox"/>	Fever >38° C	
	<input type="checkbox"/>	<input type="checkbox"/>	Rigor or chills	
	<input type="checkbox"/>	<input type="checkbox"/>	Cough	
	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	
	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	
	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	
	<input type="checkbox"/>	<input type="checkbox"/>	Myalgia	
	<input type="checkbox"/>	<input type="checkbox"/>	Headache	
	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	
	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	
<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

<b>Name of Contact:</b>				
<b>Date of Surveillance</b>	<b>Symptoms</b>		<b>Daily Assessment (Check one)</b>	
<b>Day 5</b> <b>Date (dd/mm/yyyy)</b> ____ / ____ / _____	<b>Yes</b>	<b>No</b>	<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic	
	<input type="checkbox"/>	<input type="checkbox"/>		Fever >38° C
	<input type="checkbox"/>	<input type="checkbox"/>		Rigor or chills
	<input type="checkbox"/>	<input type="checkbox"/>		Cough
	<input type="checkbox"/>	<input type="checkbox"/>		Shortness of breath
	<input type="checkbox"/>	<input type="checkbox"/>		Sore throat
	<input type="checkbox"/>	<input type="checkbox"/>		Arthralgia
	<input type="checkbox"/>	<input type="checkbox"/>		Myalgia
	<input type="checkbox"/>	<input type="checkbox"/>		Headache
	<input type="checkbox"/>	<input type="checkbox"/>		Vomiting
	<input type="checkbox"/>	<input type="checkbox"/>		Diarrhea
	<input type="checkbox"/>	<input type="checkbox"/>	Other_____	
<b>Day 6</b> <b>Date (dd/mm/yyyy)</b> ____ / ____ / _____	<b>Yes</b>	<b>No</b>	<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic	
	<input type="checkbox"/>	<input type="checkbox"/>		Fever >38° C
	<input type="checkbox"/>	<input type="checkbox"/>		Rigor or chills
	<input type="checkbox"/>	<input type="checkbox"/>		Cough
	<input type="checkbox"/>	<input type="checkbox"/>		Shortness of breath
	<input type="checkbox"/>	<input type="checkbox"/>		Sore throat
	<input type="checkbox"/>	<input type="checkbox"/>		Arthralgia
	<input type="checkbox"/>	<input type="checkbox"/>		Myalgia
	<input type="checkbox"/>	<input type="checkbox"/>		Headache
	<input type="checkbox"/>	<input type="checkbox"/>		Vomiting
	<input type="checkbox"/>	<input type="checkbox"/>		Diarrhea
	<input type="checkbox"/>	<input type="checkbox"/>	Other_____	
<b>NOTES</b>				