Form 5. Avian influenza exposed person investigation and monitoring

Exposed person unique identifier (assigned by public health)	
Form completion details	
Date of initial form completion (DD/MM/YY) / /	Time of initial form completion :
Name of person completing form	Position of person completing form
Institution / organisation	
Telephone	Mobile
Exposed person details	D. Alid ODDA DAMA
Name	Date of birth (DD/MM/YY) / /
Surname	Age years months
Gender Male Female	
Address (Regular)	
Postcode	
Telephone	Mobile
Address (in past 2 weeks if different from regular)	
Occupation	
Health care worker	Yes No No
Laboratory worker	Yes No
Veterinary	Yes 🗌 No 🔲
Poultry worker	Yes 🗌 No 🗌
Other (specify)	
Travel in the last 2 weeks	Yes No
If yes, where? (country, administrative district)	
General Practitioner details	
Name of general practitioner (GP)	
GP address (regular)	
Postcode	
GP telephone	
Starting point of exposed person tracing	
Human case* exposure	
Exposed to a human case*?	Yes 🗌 No 🗌
Laboratory exposure	
Potential exposure to influenza A/H5N1 from a sample?	Yes No No
Animal / environmental exposure	
Shared exposure with a human case*?	Yes No No
Other animal / environmental exposure NOT shared with a human case*?	Yes No No

^{*} Probable or confirmed

Human case* Exposure - If exposed to a human case* (If more	than a human case, please complete table as necessary)
Human case*	
Human case* unique identifier	
Date of onset of symptoms of human case*	(DD/MM/YY) / /
Date of notification of human case*	(DD/MM/YY) / /
Relationship with human case*	
Details of exposure to human case*	
Period of Exposure FROM	(DD/MM/YY) / /
Period of Exposure TO	(DD/MM/YY) / /
Duration of exposure	
Type of exposure	
Further details of exposure	

Laboratory Exposure - If potential exposure to influenza A	/H5N1 from a sample	
Details of exposure to influenza A/H5N1 from a sample		
Human case* unique identifier (sample)		
Period of Exposure FROM	(DD/MM/YY) / /	
Period of Exposure TO	(DD/MM/YY) / /	
Duration of exposure		
Type of exposure		
Place of exposure (hospital /laboratory)		
Further details of exposure		

Animal / Environmental Exposure - If shared exposure with a	human case*
Human case* with whom exposure has been shared	
Human case* unique identifier (assigned by public health)	
Details of shared exposure with a human case*	
Shared Exposure n	
Exposure**	
If animal, healthy / sick / dead?	
Period of exposure FROM	(DD/MM/YY) / /
Period of exposure TO	(DD/MM/YY) / /
Nature of exposure	
Duration of exposure	
Location of exposure***	
Further details of exposure	

Other Animal / Environmental Exposure - If NOT shared with a human case* Other Exposure NOT shared with a human case* Other Exposure n Exposure** If animal, healthy / sick / dead? Period of exposure FROM (DD/MM/YY) / / Period of exposure TO (DD/MM/YY) / / Nature of exposure Duration of exposure Location of exposure** Further details of exposure

NOTE: Insert additional pages if needed

^{*} Probable or confirmed

^{**} Species

^{***} Family farm/backyard, poultry factory, live market, culling, food processing (butcher, cook...), veterinarian, other

Yes No	Clinical monitori	ing																
Day 0					t know	n expo	osure (a	s abo	ve)									
Yes No	Day 0 is the day o	of the last know											7					
Cough						_				_		_				Day 7		
Shortness of breath	F 200G (1)	res	NO	res	NO	res	NO	res	No	res	NO		No	res	NO	res	No
Shortness of breath	` `	asurea)	<u> </u>			<u> </u>	屵	<u> </u>	H	片				<u> </u>		\vdash		
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Has the exposed person developed symptoms since the last known exposure? Yes No □ If the exposed person falls ill → Complete Form 1 Date of onset of symptoms (DD/MM/YY) / / Antiviral chemoprophylaxis Antiviral chemoprophylaxis given to exposed person? Yes No □ If yes → Complete Form 7 Medication (generic name and brand name) Route of administration (quantity many and unit of measure) Prophylaxis Prophylaxis Prophylaxis			<u> </u>	<u> </u>		<u> </u>		<u> </u>		<u> </u>		<u>Ц</u>		<u>Ц</u>		<u> </u>		<u> </u>
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Antiviral chemoprophylaxis Antiviral chemoprophylaxis given to exposed person? Yes □ No □ If yes → Complete Form 7 Medication (generic name and brand name) Prophylaxis Route of administration (quantity and unit of measure) Prophylaxis Prophylaxis Antiviral chemoprophylaxis Route of administration (quantity and unit of measure) Dose How many times a day? Dob/MM/YY started DD/MM/YY fin in times a day?	If the exposed per	\rightarrow son falls ill \rightarrow	Com	plete F	orm 1													
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