Appendix F: BC Outbreak Reporting Questionnaire - April 2004

The questionnaire that follows was developed by the BC Centre for Disease Control (BCCDC) for use during the 2004 avian influenza H7N3 outbreak in British Columbia with input from scientists who were previously involved in the response to an avian influenza H7N7 outbreak in the Netherlands in 2003.

Avian Influenza in British Columbia
Initial Report Surveillance Form, 2004

When completed, please fax to the attention of: Dr._____, BCCDC, 604-_____

SUGGESTED OPENING SCRIPT:

Hello. My name is:_____. I am a public health nurse from _____ (health unit).

As part of our duties under the Health Act, we are following-up with people who may have been exposed to avian influenza, otherwise known as "bird flu". The avian influenza virus causing outbreaks in poultry in British Columbia may have caused some illness in people who have had contact with infected birds. This form of influenza virus has never before been known to cause illness in humans.

For this reason, it is very important that we collect detailed information about this outbreak and any possible illness in people. All identifying information that is collected will be kept private and confidential and shared only with public health officials who need to know in order to understand and contain this outbreak. Depending on the information we collect, this may take up to 20 minutes. Are you ready to begin? **If no,** when would be a better time?_____

[If interview not proceeding well] Is there someone else that I should speak to instead in your home (or farm etc) related to this outbreak? If so, who? _____ (name/contact information)

Please use back of page for additional notes, including commentary on relevant details & dates (e.g., direct exposures, incidents, personal protection equipment, etc.).

Section I. HEALTH AUTHORITY INFORMATION

Is this a NEW report or an UPDATE? Date of report *(dd/mm/yyyy)*: ____/____/_____

PHN/Person Reporting: _____ Health Unit Reporting: _____

Phone: _____ Province Reporting:_____

Section II. PERSONAL INFORMATION

Assigned ID: ____/____/_____ (Initial of last name, Initial of first name, age in years)

[NOTE: All symptomatic workers from outside of BC will be reported to the applicable provincial epidemiologist by the BC Centre for Disease Control & vice-versa]

Last name:_____ First name: _____

Home Address: _____ Home City: _____

Province of Residence: _____ Postal Code: _____

Phone Numbers in Province of Residence:_____ (home, office &/or, cell)

Address while in BC if different from above:_____

Phone Number(s) while in BC if different from above:_____

Planned date of return to Province of Residence (if applicable): *(dd/mm/yyyy)*: ____/____/_____

What is your occupation? _____ Employer:_____

Public health please indicate appropriate relationship based on occupation/employer:

Relationship to Farm: ☐ Farm owner ☐ Family member of owner ☐ Farm employee
☐ CFIA worker ☐ Other *(specify)*: _____

Date of Birth *(dd/mm/yyyy)*: ____/____/_____ or Age:_____*yrs* Gender: ☐ Male ☐ Female ☐ Unknown

Section III. SYMPTOMS

1. Have any of the following eye symptoms started or become worse than usual since February 06, 2004? *(Tick all that apply.* ***Please record only NEW or WORSE symptoms****)*

Red eye(s)	☐ One eye	☐ Both eyes	Teary eye(s)	☐ One eye	☐ Both eyes
Burning eye(s)	☐ One eye	☐ Both eyes	Painful eye(s)	☐ One eye	☐ Both eyes
Itching eye(s)	☐ One eye	☐ Both eyes	Pus in eye(s)	☐ One eye	☐ Both eyes
Sensitivity to light	☐ One eye	☐ Both eyes			

   If yes, what day did the first of these symptoms start *(dd/mm/yyyy)*? ____/____/_____
   If yes, how would you rate these symptoms? ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown
   If yes, did these symptoms start suddenly or gradually? ☐ Suddenly ☐ Gradually ☐ Unknown

2. Have any of the following influenza-like symptoms started or become worse than usual since February 06, 2004? *(Tick all that apply.* ***Please record only NEW or WORSE symptoms****)*

☐ Fever → Temperature _____	☐ Cough	☐ Runny Nose
☐ Sore Throat	☐ Headache	☐ Muscle Aches
☐ Fatigue	☐ Diarrhea	☐ Joint Aches
☐ Chills	☐ Sweats	

   If yes, what day did these symptoms start *(dd/mm/yyyy)*? ____/____/_____
   If yes, how would you rate these symptoms? ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown
   If yes, did these symptoms start suddenly or gradually? ☐ Suddenly ☐ Gradually ☐ Unknown

3. Did you have any other symptoms that started or became worse than usual since February 06 2004 that you think may have resulted from contact with poultry? ☐ Yes ☐ No ☐ Unknown
   If yes, please describe your symptoms:

   _____
   _____
   _____
   _____

   If yes, what day did these symptoms start *(dd/mm/yyyy)*? ____/____/_____

If respondent reports any of the symptoms mentioned above, please make arrangements to collect serum, eye swabs and nasaopharyngeal swabs for laboratory testing.

Section IV. CONTACTS

1. How many people live in the same house as you (not including yourself)? _____
2. Besides other people living in your household, with how many people do you have close personal contact? This may include family members, intimate partners, etc. _____
3. Have any of your household members or other personal close contacts told you that they have had any of the symptoms I mentioned earlier? ☐ Yes ☐ No ☐ Unknown
4. **If yes,** what is/are their name(s), what symptoms did they experience, and how may we contact them?

Name	**Relationship**	**Symptoms**	**Onset** *(dd/mm/yyyy)*	**Contact Number**
			/ /	
			/ /	
			/ /	
			/ /	

For public health completion: Are these ill contacts potential products of person-to-person transmission?
☐ Yes ☐ No ☐ Unknown Please explain (yes or no): _____

If the respondent did not have any symptoms please continue with Section VII, « Other People Exposed » on page 5.

Section V. CLINICAL INFORMATION

1. Did you see a physician for your symptoms? ☐ Yes ☐ No ☐ Unknown
   If yes, was the physician a *(tick all that apply)*: ☐ General Practitioner or a ☐ Specialist
   If yes, what was the diagnosis? _____

   Physician Name **Physician Address/Phone Number**

   _____
   _____
   _____
   _____

2. Did you go to an Emergency Room for these symptoms? ☐ Yes ☐ No ☐ Unknown
   If yes, where:_____ If yes, when *(dd/mm/yyyy)* ____/____/_____

3. Were you hospitalized overnight for these symptoms? ☐ Yes ☐ No ☐ Unknown
   If yes, where:_____ If yes, when *(dd/mm/yyyy)* ____/____/_____

4. Did you have a chest X-ray taken because of these symptoms? ☐ Yes ☐ No ☐ Unknown
   If yes, where: _____ If yes, when *(dd/mm/yyyy)* ____/____/_____
   If yes, what was the result: _____

5. How are you feeling today? ☐ The Same ☐ Better ☐ Worse ☐ Completely Recovered
   If recovered, what was the first day that you no longer had any symptoms? *(dd/mm/yyyy)* ____/____/_____

6. Have you received influenza vaccination since September 2003? ☐ Yes ☐ No ☐ Unknown
   If yes, date? *(dd/mm/yyyy)* ____/____/_____
   If yes, why?
   - ☐ Age over 65
   - ☐ Diabetes
   - ☐ At my own request
   - ☐ Offered through work before Feb 06, 2004
   - ☐ Lung disease (e.g. asthma, emphysema, COPD)
   - ☐ Immune deficiency
   - ☐ Because of avian influenza (after Feb 06, 2004)
   - ☐ Other (specify) _____

7. Have you taken anti-viral medications (e.g. Tamiflu or Amantadine) since February 06, 2004?
   - ☐ Yes, as a treatment for eye/influenza symptoms
   - ☐ Yes, as a preventative measure due to exposure to poultry
   - ☐ Yes, for another reason (specify) _____
   - ☐ No
   - ☐ Unknown

   If yes, specify name (e.g. Tamiflu or Amantadine): _____
   If yes, how many tablets did you take each day? _____
   Start date: ____/____/_____ Stop date: ____/____/_____

8. Are you currently a smoker? ☐ Yes ☐ No **If yes,** how many packs do you smoke each day? _____
   For how many years have you smoked?_____

Section VI. EXPOSURE INFORMATION

1. Since February 6, 2004 have you had contact with poultry, poultry products, or poultry manure?
   ☐ Yes ☐ No ☐ Unknown **If yes,** When was your first contact/exposure? *(dd/mm/yyyy)* ____/____/_____
   When was your last contact/exposure? *(dd/mm/yyyy)* ____/____/_____

2. Do any of these statements apply to you (tick **all** that apply)?

a)	I own a poultry farm	☐ Yes	☐ No	☐ Unknown
b)	I live on a poultry farm	☐ Yes	☐ No	☐ Unknown
c)	I am a family member or household contact of a poultry farmer	☐ Yes	☐ No	☐ Unknown
d)	I am employed by a poultry farm	☐ Yes	☐ No	☐ Unknown
e)	I am a veterinarian	☐ Yes	☐ No	☐ Unknown
f)	I have been helping cull poultry	☐ Yes	☐ No	☐ Unknown
g)	I have been transporting poultry carcasses	☐ Yes	☐ No	☐ Unknown
h)	I have been working at an incinerator	☐ Yes	☐ No	☐ Unknown
i)	Other (please specify): _____			

3. What poultry farm(s) have you visited or worked on since Feb 6, 2004? Were these infected with avian influenza? *(Last 4 columns to be completed by public health staff with information from CFIA.)*

Name of Farm	Farm Location	Infected?	Date Positive *(dd/mm/yyyy)*	Date Culled *(dd/mm/yyyy)*	Date Clean *(dd/mm/yyyy)*
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			

4. Have you participated in any of the following activities ***(Please tick all that apply)***?

a)	I have not been directly involved with poultry	☐ Yes	☐ No	☐ Unknown
b)	I worked at an incinerator	☐ Yes	☐ No	☐ Unknown
c)	I worked in a slaughter house	☐ Yes	☐ No	☐ Unknown
d)	I brought equipment to farms (e.g. equipment to gas flocks)	☐ Yes	☐ No	☐ Unknown
e)	I worked with carbon dioxide gas to euthanize the birds	☐ Yes	☐ No	☐ Unknown
f)	I collected eggs	☐ Yes	☐ No	☐ Unknown
g)	I was in direct contact with surfaces that may have been contaminated by poultry	☐ Yes	☐ No	☐ Unknown
h)	I was in direct contact with manure from the poultry	☐ Yes	☐ No	☐ Unknown
i)	I shared a confined air space with infected or potentially infected poultry	☐ Yes	☐ No	☐ Unknown
j)	I assessed the health of poultry	☐ Yes	☐ No	☐ Unknown
k)	I caught live poultry	☐ Yes	☐ No	☐ Unknown
l)	I had other contact with live poultry (specify) _____	☐ Yes	☐ No	☐ Unknown
m)	I collected dead poultry	☐ Yes	☐ No	☐ Unknown
n)	I had other contact with dead poultry (specify)_____	☐ Yes	☐ No	☐ Unknown
o)	I loaded / unloaded poultry carcasses into / out of trucks	☐ Yes	☐ No	☐ Unknown
p)	Other (please specify): _____			

5. Do you wash your hands after such exposure/activities? ☐ Yes ☐ No ☐ Unknown
   If yes, is this: ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely

6. **If you have been exposed to potentially infected poultry,** were you wearing any of the following during your exposure? (tick all that apply)
   ☐ Gloves ☐ Mask (Type_____) ☐ Goggles ☐ Safety glasses
   ☐ Impermeable Coveralls ☐ Disposable shoes or shoe covers ☐ Head and hair cover
   ☐ Disposable Outer garments ☐ Boots that you clean and disinfect after exposure and wear again
   ☐ Outer garments that you wash and wear again

Section VI. EXPOSURE INFORMATION cont.

7. Can you remember any concerning incidents in terms of exposure? Please describe. Please keep in mind that all of this information will be kept confidential (use space overleaf if necessary).

   _____

8. Have you had close contact with a person who lives/works on a poultry farm and who has/had respiratory or eye symptoms? ☐ Yes ☐ No ☐ Unknown

   By close contact, we mean family members, roommates, intimate partners, etc.

   If yes, who (and relationship to you)? _____

   If yes, date of first exposure *(dd/mm/yyyy)*: ___/___/_____ Date of last exposure*(dd/mm/yyyy)*: ___/___/_____

People at increased risk:

9. Are there any children in your household? ☐ Yes ☐ No ☐ Unknown
10. Are there any elderly people in your household? ☐ Yes ☐ No ☐ Unknown
11. Do you have a heart or lung condition? ☐ Yes ☐ No ☐ Unknown
12. Do you have any other chronic conditions? ☐ Yes ☐ No ☐ Unknown

    If yes to any other chronic conditions, specify: _____

13. Have you been told that you have a weak immune system? ☐ Yes ☐ No ☐ Unknown

    This could be due to a health condition (e.g. cancer, HIV) or medications that you may be taking.

    If yes to a weak immune system, specify: _____

14. Do you have a chronic eye condition? ☐ Yes ☐ No ☐ Unknown

    If yes to a chronic eye condition, specify:_____

15. Do you have any allergies? ☐ Yes ☐ No ☐ Unknown

    If yes, to any allergies: ☐ Food ☐ Dust, dander, pollen ☐ Medication ☐ Other, sp:_____

If any elderly people, children or persons with weak immune systems or chronic conditions are in the household, these persons should be strongly encouraged to avoid any contact with poultry that may be infected.

Section VII. OTHER PEOPLE EXPOSED

If exposed at a farm: Have any other people had close contact with infected birds at the same farm as yourself (direct handling of birds or manure or shared the same confined airspace as infected birds)?

☐ Yes ☐ No ☐ Unknown; If yes, how many people?_____

If yes, what are their names? What symptoms did they experience? What are their phone numbers?

Name	**Symptoms (specify, or indicate none or unknown)**	**Contact Number**

Thank you very much for taking the time to answer our questions. This is the first time this form of avian influenza virus has caused illness in people. There may be other questions we need to ask you as part of our public health follow-up and if so we may call you back. You are also free to call us anytime if you have any questions at:_____.

Finally, if special studies are set up in the future to understand avian influenza viruses, would you be interested in hearing about these? ☐ Yes ☐ No

NOTE TO INTERVIEWER: Conclude with relevant public health recommendations and offer to send "Dear Poultry Farmer" letter or other information if appropriate and not already received.