# Influenza A H1N1 Death Summary Form

(Proforma to be filled up for the Influenza A H1N1 confirmed patients who have died)

**I. Reported by:**

1. Name of the hospital with address:

**II. Patient Identification Data:**

1. Name:_____

2. Date of Birth (dd/mm/yy) - -/- -/---- Age (in yrs): - -

3. Sex ☐ Male ☐ Female

*If Female*, was the patient pregnant? ☐Yes (weeks pregnant) ____☐No ☐Unknown

4. Residential status: ☐Urban ☐Rural, specify address with contact telephone no. (mobile preferred) of family member

**III. Clinical Data (Please tick one or more than one symptoms/ailments the patient had)**

1. Signs and symptoms with date of onset (dd/mm/yy) : - -/- -/----

| | Duration (in days) | | Duration (in days) |
|---|---|---|---|
| ☐ Mild fever | ▭ | ☐ High grade fever | ▭ |
| ☐ Cough | ▭ | ☐ Breathlessness | ▭ |
| ☐ Headache& bodyache | ▭ | ☐ Chest pain | ▭ |
| ☐ Running of nose | ▭ | ☐ Fall in blood pressure | ▭ |
| ☐ Sore throat | ▭ | ☐ Sputum with blood | ▭ |
| ☐ Vomiting | ▭ | ☐ Any other, specify | ▭ |
| ☐ Diarrhoea | ▭ | | |

2. Did the patient had any high risk illness / predisposing condition

i) Cortisone therapy + Immuno suppressive therapy Yes ☐ No ☐ Unknown

ii) HIV +ve only Yes ☐ No ☐ Unknown

iii) AIDS Yes ☐ No ☐ Unknown

iv) Diabetes mellitus Yes ☐ Controlled ☐ Uncontrolled ☐ No ☐ Unknown

v) Chronic Lung disease (specify with duration) _____

vi) Chronic Heart disease (specify with duration) _____

vii) Chronic Kidney disease (specify with duration) _____

viii) Chronic Liver disease (specify with duration) _____

ix) Cancer (specify with duration) _____

x) Blood disorders (specify with duration)_____

xi) Neurological disorders (specify with duration)_____

xii) Any other (specify with duration) _____

3. Diagnostic Findings (clinical) :

3.1. General tests:

Did the patient have any of the following tests?

☐ Chest x ray If yes, ☐ Normal ☐ Abnormal ☐ Unknown

☐ Chest CT scan If yes, ☐ Normal ☐ Abnormal ☐ Unknown

If chest x- ray or chest CT scan result abnormal:
Was there evidence of pneumonia?

☐ Yes ☐ No ☐ Unknown

3.2. Influenza testing:

Date of collection of sample: ___//___//___
Date of declaration of result: :___//___//___
Name of the lab. which conducted test:

Result:

4. Treatment details

4.1. Previous treatment history

I. Oseltamivir with duration

II. Treatment for other symptoms

III. Name of the Hospitals/health facilities/private practitioner where treatment taken with dates

4.2. Treatment given in the hospital where patient died

I. Date of admission:____//__//__

II. Date of death: :____//__//____ Cause of Death: _____

III. Did the patient receive Oseltamivir?
   a. If yes, complete table below:

| **Drug** | **Date initiated** | **Date discontinued** | **Dosage( if known)** |
|---|---|---|---|
| Oseltamivir | | | |
| Zanamivir | | | |

IV. Treatment for complications (details)

V. Did the patient require mechanical ventilation? ☐ Yes ☐No ☐ Unknown

(Signature of Treating Doctor / Medical Superintendent)
Date: