

ATYPICAL H1N1 CASE REPORT

Please FAX to: Brigid O'Connor, RN and Shelly Meyer, RN, C
Missoula City-County Health Department
Phone: 1-406-258-3896 or FAX: 1-406-258-3610

Case Name:		DOB: ____ / ____ / ____	
Address:		Phone:	
City and County		Zip	
Age:	Sex: M F	Race: White Black A. Indian/alaskan Asian Hispanic unknown	
CLINICAL DIAGNOSIS/SPECIMEN COLLECTION			
Disease H1N1		<input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed	
Date of Onset:			
Specimen Collection Date:	Rapid Test Result:	Lab Date/Diagnosis Date:	
Local Lab:	Reported by:	Date Reported to Health Dept.:	
FEVER: yes no uk	TEMP: _____°F	COUGH: yes no uk	HEADACHE : yes no uk
SEIZURES: yes no uk	RHINORRHEA: yes no uk	DIARRHEA: yes no uk	VOMITING: yes no uk
SORE THROAT: yes no uk	CONJUNCTIVITIS: yes no uk	SHORTNESS OF BREATH: yes no uk	
OTHER:		VACCINATED for Flu: yes no uk	
Received Antiviral Meds: yes no uk If yes: NAME _____ DOSE _____			

Provider Information:

Provider:	Clinic:	Phone:
For More Info, Contact:		City:

Comments:

Local Health Dept. Reviewer: