

## Supplementary WHO H5N1 Clinical Case Data

Please fax or email to WHO Global Influenza Programme- Fax +41 22 7914878 email [influenzadata@who.int](mailto:influenzadata@who.int)

Name of submitter _____	Date of submission <u>dd/mm/yy</u>
Email/Tel. number <u>enter your email address and/ or tel. n° here</u>	

Patient ID _____	Patient Initials <u>Patient's initials</u>
Country of residence _____	Place/city of residence _____
Age (years) _____	Sex (check one) Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of illness onset <u>dd/mm/yy</u>	Patient weight (kg) _____

### Viral detection results (including follow-up samples)

	Date of Sampling	RT-PCR	Virus Culture	Other (Specify)	Positive	Negative
Throat	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Serum/Plasma	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Nasal	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Tracheal	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

	Date of Sampling	RT-PCR	Virus Culture	Other (Specify)	Positive	Negative
Throat	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Serum/Plasma	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Nasal	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Tracheal	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

	Date of Sampling	RT-PCR	Virus Culture	Other (Specify)	Positive	Negative
Throat	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Serum/Plasma	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Nasal	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Tracheal	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

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### Viral susceptibility testing

Was viral susceptibility testing performed? Yes  No

If testing was performed, please fill in the section below-

Type of Sample (specify)	Date	Enzyme inhibition	Sequencing	Cell Culture	Agent tested (specify)	Susceptible	Resistant	Specify mutation
_____	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<u>dd/mm/yy</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Plasma antiviral concentration

Date of Sampling	Antiviral (Specify)	Type of dosing (specify)	Route of dosing (specify)	Time of sampling since last dose	Specimen sent to reference lab	Specimen not sent to reference lab	Concentration in ng/ml
<u>dd/mm/yy</u>	_____	_____	_____	____h ____min	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>dd/mm/yy</u>	_____	_____	_____	____h ____min	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>dd/mm/yy</u>	_____	_____	_____	____h ____min	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>dd/mm/yy</u>	_____	_____	_____	____h ____min	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>dd/mm/yy</u>	_____	_____	_____	____h ____min	<input type="checkbox"/>	<input type="checkbox"/>	_____