**HPAI Contact Questionnaire**

*Hi, my name is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I am calling on the behalf of NC DPH and \_\_\_\_\_\_ county health department. This call is regarding your recent exposure to ill birds. I would like to ask you some questions and help determine the level of assistance you may need from the health department.*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_\_\_\_ County of Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please select Y/N**

Deployed? Yes No Farm worker Yes No

USDA Employee? Yes No Visitor Yes No

NCDA Employee? Yes No Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Where did the exposure(s) occur (Name of Farm, Address, City, and/or County)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What was the date of **FIRST** contact with infected birds (includes take down and set up of equipment, animal contact and depopulation activities): \_\_ /\_\_ /\_\_\_\_\_
3. What was the date of **LAST** contact with infected birds (includes take down and set up of equipment, animal contact and depopulation activities):\_\_\_ /\_\_ /\_\_\_\_\_
4. Did you wear personal protective equipment (PPE) during all direct exposure to sick or dead birds or infected flocks (direct exposure includes: contact with birds [e.g., handling, slaughtering, defeathering, butchering, preparation for consumption]; direct contact with surfaces contaminated with feces or bird parts [carcasses, internal organs, etc.]; or prolonged exposure to birds in a confined space)? **[ ] Yes [ ] No [ ] Unknown**
5. Are you taking antivirals (oseltamivir, zanamivir) for influenza related to this exposure? **[ ] Yes [ ] No** 
   1. If yes, what was the start date? \_\_ /\_\_ /\_\_\_\_\_
   2. if yes, what was the end date? \_\_ /\_\_ /\_\_\_\_\_
6. Are you under daily monitoring (self-monitoring/active monitoring)? [ ] Yes [ ] No

**Symptoms**

1. Do you have any signs and symptoms (read off list/symptom log) of influenza infection? [ ] Yes [ ] No
   1. If yes, which signs and symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* 1. Date of symptom onset \_\_ /\_\_ /\_\_\_\_\_

1. Do you need or plan to visit a provider? (Please circle: ED, Clinic, Provider) [ ] Yes [ ] No
   1. Please list provider information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Testing**

1. Influenza testing done? [ ] Yes [ ] No
2. Date of specimen collection \_\_ /\_\_ /\_\_\_\_\_

**Treatment**

1. Antivirals prescribed? [ ] Yes [ ] No
   1. If yes, what was the start date? \_\_ /\_\_ /\_\_\_\_\_
   2. if yes, what was the end date? \_\_ /\_\_ /\_\_\_\_\_