

AFIX PATIENT DETAILS LABEL HERE IF AVAILABLE

Name   Male  
 Female  
 Date of birth          
 NHS Number            
 Hospital Number

DATE:  
TIME:

<b>PRESENTING FEATURES:</b>	<b>REFERRAL SOURCE</b>
	GP <input type="checkbox"/>
	Self <input type="checkbox"/>
	Other <input type="checkbox"/>

**PREVIOUS**  
 Vaccine?<sup>1</sup>       Oseltamivir?<sup>2</sup>       Previous Attendance?<sup>3</sup>

<b>ANTIBIOTIC THERAPY THIS ILLNESS?</b> <i>(Drug and duration)</i>	Symptom duration (days)
None <input type="checkbox"/>	

**CURRENT MEDICATION** None

**ALLERGIES** None

**PAST MEDICAL HISTORY**

**PATIENT CRITERIA** *(tick if applicable)*  
 Social Isolation (Patient lives alone/ no fixed abode)

**PERFORMANCE STATUS** *(tick one)*

Unrestricted normal activity <input type="checkbox"/>	Limited strenuous activity, can do light <input type="checkbox"/>
Limited activity, can self care <input type="checkbox"/>	Limited self care <input type="checkbox"/>
Bed/chair bound, no self care <input type="checkbox"/>	

**CHRONIC DISEASE** *(tick if applicable)*

Heart disease <input type="checkbox"/>	Other chronic lung disease <input type="checkbox"/>
Renal Impairment <input type="checkbox"/>	Diabetes <input type="checkbox"/>
Steroid Therapy <input type="checkbox"/>	Active malignancy <i>(last 6 months)</i> <input type="checkbox"/>
Asthma <input type="checkbox"/>	Immunosuppression <input type="checkbox"/>

Verbal   
 Leaflet   
 WITHDRAWN CASE?

**PANDEMIC INFLUENZA FORM**

<sup>1</sup>Yes if any previous vaccine    <sup>2</sup>Yes if any use of oseltamivir in current illness  
<sup>3</sup>Yes if previous attendance at emergency dept. for this problem Version 3.1. 17<sup>th</sup> May 2013

ROUTINE VACCINATIONS?	<input type="checkbox"/>	PAEDIATRIC ONLY		CLINICALLY OBESE?	<input type="checkbox"/>
TAKING FEEDS?	<input type="checkbox"/>	PREMATURE*	<input type="checkbox"/>	PREGNANT?	<input type="checkbox"/>
		PARENTAL ANXIETY	<input type="checkbox"/>		

### CLINICAL EXAMINATION

DIAGNOSIS?  INFLUENZA (PANDEMIC OR SEASONAL)  OTHER:

Respiratory Rate		Severe respiratory distress <sup>1</sup>	<input type="checkbox"/>	Respiratory exhaustion	<input type="checkbox"/>					
Pulse Rate		<b>OTHER CLINICAL CONCERNS:</b> (Additional questions should be written here)								
Temperature										
Blood Pressure										
SaO <sub>2</sub>	FiO <sub>2</sub>									
Central capillary refill	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>									
GCS-E	GCS-V	GCS-M	<b>INVESTIGATIONS</b>		<b>BLOODS TAKEN</b> <input type="checkbox"/>					
A	V	P	U	Na	K	Urea	Creat	Hb	Plate	WCC
CXR	Not done <input type="checkbox"/>	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>							
ECG	Not done <input type="checkbox"/>	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>							

### DISPOSITION AND CLINICAL PLAN

*Oseltamivir*  *Antibiotic*.....

Clinician Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Grade: \_\_\_\_\_

Disposed to: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

## PANDEMIC INFLUENZA FORM

<sup>1</sup>Severe respiratory distress (accessory muscles, tracheal tug, feeling of suffocation, apnoea)

\*Premature defined as birth before 37 weeks gestation.