



Canine Influenza Virus (CIV)

Confirmed **Suspected**

Reporting Instructions (Note: All reporting is voluntary)

Please fill out and submit this form for each individual case of Confirmed or Suspected CIV your facility encounters. Fax form along with laboratory results to: (206) 296-0189, Attention: Public Health Veterinarian.

CIV Reporting Case Definitions:

Confirmed: Any dog with laboratory tested and confirmed CIV positive sample.
Suspected: Any dog with symptoms and history for CIV from the SAME household as a dog with a CONFIRMED case of CIV or a known exposure to a dog with a CONFIRMED case of CIV, but no positive test.

REPORT SOURCE

Report Date (MM/DD/YY): ____/____/____
 Veterinarian: _____
 Facility/Clinic Phone: (____) _____
 Facility/Clinic Name and Address:

PATIENT INFORMATION

Name of dog: _____
 Last name of owner: _____
 Breed: _____
 DOB or Age: _____
 Gender: Male Female
 Neutered/Spayed: Yes No
 Zip code of dog's residence: _____

CLINICAL INFORMATION

Date of onset of illness (MM/DD/YY): ____/____/____

Cough:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nasal Discharge:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, what was highest known temperature during illness? _____		
Sneezing:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lethargy:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anorexia:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Recovered Still sick/recovering Died

Underlying or chronic medical conditions? Yes No
 Please list conditions:

IMMUNIZATION HISTORY

Has the dog ever received a Canine Influenza Virus vaccine?
 Yes No Unknown

If yes, which type? (mark all that apply):
 H3N8 H3N2

Did the dog receive an initial vaccination and a booster vaccine 2-4 weeks later?

H3N8 Yes No Unknown
 H3N2 Yes No Unknown

Last vaccination given in the past year?

H3N8: Yes No Unknown
 H3N2: Yes No Unknown

EXPOSURE RISK			
In the past month, has the patient had exposure to other dogs in:			
Dog Daycare Facility:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Kennel/Boarding Facility:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Grooming Facility:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Dog Park or Off Leash Area:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Dog Play Group:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Obedience/Training Class:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Veterinary Facility (prior to showing clinical signs):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Other (specify):			
Any other dogs in household ill?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
LABORATORY TESTING	LABORATORY RESULTS		
Collection date of sample(s) (MM/DD/YY): ____/____/____	<u>Please send a copy of laboratory results</u>		
Days from onset of illness: _____	Positive results for: <input type="checkbox"/> H3N8 <input type="checkbox"/> H3N2		
Samples taken (mark all that apply): <input type="checkbox"/> Serum	<input type="checkbox"/> Canine influenza- unknown strain		
<input type="checkbox"/> Nasal swab <input type="checkbox"/> Pharyngeal swab <input type="checkbox"/> Ocular swab	Laboratory results (mark one result for each test submitted):		
<input type="checkbox"/> Transtracheal Wash (TTW) <input type="checkbox"/> Bronchoalveolar Lavage (BAL)	<input type="checkbox"/> PCR <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Inconclusive		
Name of laboratory: _____	<input type="checkbox"/> Serology (HI/HAI): <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Inconclusive		
_____	<input type="checkbox"/> Virus Isolation <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Inconclusive		
Laboratory tests (mark all that apply):	<input type="checkbox"/> Other <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Inconclusive		
<input type="checkbox"/> PCR	Other positive results (e.g. respiratory panel or other tests done):		
<input type="checkbox"/> Serology (HI/HAI): <input type="checkbox"/> Acute OR <input type="checkbox"/> Convalescent	_____		
<input type="checkbox"/> Virus Isolation	_____		
<input type="checkbox"/> Other (specify): _____	_____		
Other Comments:			
For questions, call (206) 263-8454 or email beth.lipton@kingcounty.gov			
If a convalescent sample is submitted in the future, please also fax these results (do not need to complete form again)			
Return form along with laboratory results to:			
Public Health – Seattle & King County, Office of the Public Health Veterinarian			
FAX: (206) 296-0189			