CASE REPORT FORM

Screening for "QUADRIFLU" project

Today's date: ……../…../……..(dd/mm/yyyy)	Name of investigator:…….. Site name: ……..
Patient's information	
First name:…… Last name: ……	Date of birth: ……../…../……..(dd/mm/yyyy)
Sex: ○ Male ○ Female ○ other	
ID number: ……..	Email address: ……..
Home phone: ……..	Mobile phone: ……..
Street address: ……..	City: …….. Province: ……..
Screening information	
○Pregnant ○lactating ○ non Urine pregnancy test ○ positive ○ negative	
Did you receive of any vaccine during the 4 weeks? ○ yes (name of vaccine……..) date of vaccination .../…./….(dd/mm/yyyy) ○ no	
Do you plan to receipt of any vaccine during the 3 weeks? ○ yes (name of vaccine……..) date of vaccination .../…./….(dd/mm/yyyy) ○ no	
Did you get vaccination against influenza in the past 6 months? ○ yes (name of vaccine……..) date of vaccination .../…./….(dd/mm/yyyy) ○ no	
Did you get influenza infection in the past 6 months ○ yes date of influenza infection .../…./….(dd/mm/yyyy) ○ no	
Do you have Chronic illness? ○ yes (if yes please provide details)……. ○ no	

CASE REPORT FORM

Enrollment for “QUADRIFLU” project

Date of visit: ……../……../……..(dd/mm/yyyy)	Name of investigator:…….. Site name: …….. Sign……..
Patient’s information	
First name:…… Last name: ……	Date of birth: ……../……../……..(dd/mm/yyyy)
Random ID: ……	
Sex: ○ Male ○ Female ○ other	
ID number: ……..	Email address: ……..
Home phone: ……..	Mobile phone: ……..
Street address: ……..	City: …….. Province: ……..
Enrollment information	
Demographic	
Date of Informed Consent Form Signed: ……../……../……..(dd/mm/yyyy)	Time of informed Consent ……../…….(hour/mimute)
Race…. Other race…..	
Vital signs	
▪ Height……cm ▪ Weight……kg ▪ Systolic…… mmHg ▪ Diastolic: ……. mmHg ▪ Pulse Rate: ……pulse per minute ▪ Respiration Rate:……breaths per minute ▪ Body Temperature:…… º C	
physical exam	
HEENT ○ Normal ○ Abnormal (if abnormal please provide details)……. **Cardiovascular Chest**	

○ Normal
○ Abnormal (if abnormal please provide details)…….

Abdomen
○ Normal
○ Abnormal (if abnormal please provide details)…….

Musculoskeletal
○ Normal
○ Abnormal (if abnormal please provide details)…….

Neurological
○ Normal
○ Abnormal (if abnormal please provide details)…….

Other Body System
○ Normal
○ Abnormal (if abnormal please provide details)…….

Is the participant eligible to take part in this study?
○ yes
○ no

Laboratory information

- Date of Sample Collection: ……../……../……..(dd/mm/yyyy)
- Time of Sample Collection: ……../…....(hour/mimute)
- A/H1N1 Antibody Titer: …….
- A/H3N2 Antibody Titer: …….
- B/Yamagata-lineage Antibody Titer: …….
- B/Victoria-lineage Antibody Titer: …….

Vaccine administration

Date of Vaccination ……../……../……..(dd/mm/yyyy)
Time of Vaccination ……../…....(hour/mimute)
Vaccination Arm
○ Left
○ Right