QUADRIFLU STUDY

CASE REPORT FORM (CRF)

SCREENING VISIT

Subject ID:	_____

Date of visit:	____ (dd)	____ (mm)	____ (yyyy)

ELIGIBILITY CRITERIA

HISTORY TAKING

Please tick the appropriate box (☐ Yes or ☐ No) for the following questions

No.	Criteria	YES	NO
1.	Pregnant or lactating		
2.	Receive any vaccine within 4 weeks		
3.	Plan to receive vaccine during the next 3 weeks		
4.	Received influenza vaccine in the past 6 months		
5.	Had influenza illness in the past 6 months		
6.	Any chronic illness		

PHYSICAL EXAMINATION

Body temperature: _____ °C

LABORATORY RESULT

Pregnancy Test: ☐ Positive ☐ Negative
(if female)

QUADRIFLU STUDY

CASE REPORT FORM (CRF)

ENROLLMENT VISIT

Subject ID:	_____

Date of visit:	____ (dd)	____ (mm)	____ (yyyy)

Informed consent obtained:

☐ Yes ☐ No

Date of consent: ____ (dd) / ____ (mm) / ____ (yyyy)

HISTORY TAKING

To confirm again: Please tick the appropriate box (☐ Yes or ☐ No) for the following questions

No.	Criteria	YES	NO
1.	Pregnant or lactating		
2.	Receive any vaccine within 4 weeks		
3.	Plan to receive vaccine during the next 3 weeks		
4.	Received influenza vaccine in the past 6 months		
5.	Had influenza illness in the past 6 months		
6.	Any chronic illness		

VITAL SIGNS

Blood Pressure: _____ / _____ mmHg (systolic / diastolic)

Heart Rate: _____ beats per minute

Respiratory Rate: _____ breaths per minute

Body Temperature: _____ beats per minute

Current Medication
☐ Yes (specify below)
☐ No

PHYSICAL EXAMINATION

☐ Normal
☐ Abnormal (specify below)

LABORATORY RESULT

Pregnancy Test: ☐ Positive ☐ Negative
(if female)

Immunogenicity status (HAI titers): _____

RAMDOMLY ASSIGNED GROUP

Please tick the randomly assigned group.

	Group A	Group B
Assigned Group		

VACCINATION CARD

Subject ID:	———————

No.	Vaccination Detail	
1	Vaccinee Name	
2	Date of Jab	**____ (dd) / _____ (mm) / _____ (yyyy)**
3	Time of Jab	**___:___ (24 hour format)**
4	Lot no.	
5	Manufacturer	
6	Route of Administration	☐ Intramuscular (IM) ☐ Subcutaneous (SC) ☐ Intradermal (ID) ☐ Oral (OP) ☐ Intranasal (NAS)
7	Site of Administration	
8	Vaccinator's name	