

Hospitalized and Fatal Cases of Influenza – Case Report Form

Patient Information

Date of Birth: _____

Last Name: _____ MI: _____ First Name: _____

Street Address: _____ City: _____ State: _____ Zip code: _____

Sex: Female Male If female, pregnant? Yes No Unknown Due date: _____

Race: White Black/African Amer. Asian Native Amer./Alaska Nat.
 Nat. Hawaiian/Other Pacific Is. Other Unknown

Ethnicity: Hispanic/Latino Yes No Unknown

Is the patient a Health Care Worker? Yes No Unknown location: _____

Is the patient a resident of a Long Term Care Facility? Yes No Unknown location: _____

Is the patient a College or University student? Yes No Unknown location: _____

Symptom onset: _____

Level of medical care (check all that apply)

Outpatient clinic ICU/PICU
 Inpatient Ward ER None

Medical record number: _____

Was case hospitalized? Yes No Unk.

Date of admission: _____

Date of discharge: _____

If hospitalized, intubated? Yes No Unk.

Did case die? Yes No Unk.

Date of death: _____

Symptoms (check all that apply)

Fever > 100° F (37.7° C) Altered mental status
 Cough Shortness of breath Sore throat
 Apnea Nausea/vomiting Seizures
 Diarrhea Rhinorrhea Muscle aches
 Headache Other: _____

Complications during acute illness (check all that apply)

Pneumonia/ARDS Encephalitis/encephalopathy
 Bronchiolitis Myocarditis
 Bacterial pneumonia Sepsis/Multi-organ Failure
 Other: _____

Antiviral use (check all that apply)

Oseltamivir (Tamiflu) Zanamivir (Relenza)
 Rimantadine Amantadine
 Other: _____

Hospital contact name: _____

Hospital name: _____

Hospital phone: _____

Past medical history and underlying conditions:

Asthma Yes No Unknown

Cancer (within the past 12 months)
 Yes No Unknown

Chronic lung disease (not asthma)
 Yes No Unknown

Chronic heart or circulatory disease
 Yes No Unknown

Diabetes and/or other metabolic disease
 Yes No Unknown

Hemaglobinopathy
 Yes No Unknown

Immunosuppressive condition (HIV infection, chronic corticosteroid or other immunosuppressive therapy, or organ transplant recipient)
 Yes No Unknown

Kidney disease
 Yes No Unknown

Neurologic/neuromuscular disorder
 Yes No Unknown

Obesity, morbid
 Yes No Unknown

Obesity, non-morbid
 Yes No Unknown

Other, specify: _____

Microbiologic Tests

Check result for each test.

Test method: _____ Collection date: _____ Pos. Neg

Rapid Test _____

IFA/DFA _____

RT PCR _____

Viral Culture _____

Other: _____

Collection date: _____

Influenza type/subtype:

Type A (H1N1) Novel 2009

Type A (H1N1) Seasonal

Type A (H3N2) Seasonal

Type A Unspecified

Type B Seasonal

Other flu type: _____

* Please report all hospitalized residents of Hartford, Middlesex and New Haven Counties to the Yale EIP. Report all other influenza hospitalizations and deaths to the DPH