

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 (fatal case only, check all that apply)

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

Antiviral use (fatal cases only, 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

Hemoglobinopathy
 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
<input type="checkbox"/> Rapid Test	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> IFA/DFA	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> RT PCR	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Viral Culture	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____		<input type="checkbox"/>	<input type="checkbox"/>
	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: _____