Print Form

Connecticut Department of Public Health, Epidemiology Program

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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^{O} 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
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: _____