Case ID_____

Adult Influenza Hospitalization Surveillance Project Case Report Form

Form Approved
OMB No. 0920-08AB
Exp. Date xx/xx/20xx

PATIENT IDENTIFIERS AND OTHER INFORMATION NOT FOR TRANSMISSION TO CDC

Last Name: _____	First Name: _____	Name Emergency Contact 1: _____	Name Emergency Contact 2: _____
Phone No.: _____	Chart Number: _____	Additional Numeric ID: _____	Additional Numeric ID: _____
Address: _____		City: _____	Zip: _____
Primary provider name: _____		Provider Phone No.: _____	

Open text field for site use:

_____

Name of person reporting this case:

Last Name: _____ First Name: _____ Date Reported: _____-_____-_____ MM-DD-YYYY

Enrollment Information

1. State (residence of patient): ____ ____	2. County: _____	3. Case I.D.: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

4. Hospital I.D. Where Patient Treated: ____ ____ ____ ____ ____

a) Admission Date: _____-_____-_____ (MM-DD-YYYY)

b) Discharge Date: _____-_____-_____ (MM-DD-YYYY)

5. Was patient transferred from another hospital: ☐ Yes ☐ No

a) If **YES**, Hospital I.D.: ____ ____ ____ ____ ____

b) Admission Date: _____-_____-_____ (MM-DD-YYYY)

c) Transfer Date: _____-_____-_____ (MM-DD-YYYY)

6. Was patient a resident of nursing home or other chronic care facility prior to hospitalization? ☐ Yes ☐ No

a) If **YES**, indicate name of facility: _____

7. Date of Birth: _____-_____-_____ (MM-DD-YYYY) 7b. Age: _____ years	8. Sex: ☐ Male ☐ Female	9. Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Not Specified	10. Race (**check all that apply**): ☐ White ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaskan Native ☐ Multiracial, unspecified ☐ Not Specified

POSITIVE Laboratory Testing Results for Influenza

1. How was the diagnosis of influenza confirmed **(check all positive tests for influenza)**:
   - ☐ Fluorescent antibody (Direct or Indirect FA)
   - ☐ RT-PCR
   - ☐ Viral culture
   - ☐ Test method unknown
   - ☐ Rapid Influenza test..……Please record name of test: _____

2. Date of first positive influenza test: _____-_____-_____ (MM-DD-YYYY)

3. Influenza virus identification (**check only one type**): ☐ Influenza A ☐ Influenza B ☐ Type unknown
   a) If **Influenza A subtype**, please specify if known: _____

4. Hospital/lab/office ID where positive result was identified (If done in a doctor's office, use the code **MDTST** or if site of flu testing is unknown, use **UNKLB) :** ____ ____ _____ _____ _____

5. Was a positive influenza test result noted in the admission H&P or discharge note? ☐ Yes ☐ No

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From the face sheet, list ICD-9 discharge diagnoses (if available)

1. ☐☐☐☐☐☐ 4. ☐☐☐☐☐☐ 7. ☐☐☐☐☐☐
2. ☐☐☐☐☐☐ 5. ☐☐☐☐☐☐ 8. ☐☐☐☐☐☐
3. ☐☐☐☐☐☐ 6. ☐☐☐☐☐☐ 9. ☐☐☐☐☐☐

From the Admission History and Physical

1. Date of onset of acute illness episode resulting in hospitalization : _____-_____-_____ (MM-DD-YYYY) ☐ Unknown

2. Did the patient have any of the following conditions? ☐ Yes ☐ No

a) If **YES**, please check all that apply:

☐ Asthma (including reactive airway disease)

☐ Cystic fibrosis

☐ Other chronic lung disease (Specify)_____

☐ Chronic cardiovascular disease (Specify)_____

☐ Chronic metabolic disease (including Diabetes) (Specify) _____

☐ Renal disease (Specify) _____

☐ Hemoglobinopathy (including Sickle Cell Disease)

☐ Neuromuscular disorder (including Cerebral Palsy) (Specify) _____

☐ Cancer diagnosis in last 12 months, excluding nonmelanoma skin cancer

☐ Immunosuppressive condition

☐ Seizure disorder

☐ History of -Guillain-Barre Syndrome

☐ History of lymphoma, leukemia

☐ Cognitive dysfunction

☐ Pregnant (Specify expected date of confinement, EDC): _____-_____-_____ (MM-DD-YYYY) ☐ Unknown

Tests, Procedures, and Interventions during the Hospital Stay

1. Chest X-Ray/CT (any during admission) ☐ Yes ☐ No

a) If **YES**, was there a new infiltrate or consolidation? ☐ Yes ☐ No

2. Mechanical ventilation ☐ Yes ☐ No

Culture Confirmation of Secondary Bacterial Pathogens

1. Was there culture confirmation of an invasive bacterial infection (sterile site)? ☐ Yes ☐ No
2. Date of first positive culture _____-_____-_____ (MM-DD-YYYY)
3. Specify the pathogen identified **(check only one)**:

☐ *Streptococcus pneumoniae*
☐ Group A *Streptococcus*
☐ *Haemophilus influenzae:* If **YES**, type b? ☐ Yes ☐ No ☐ Unknown
☐ *Staphylococcus aureus:* If **YES**, methicillin **resistant (MRSA)**? ☐ Yes ☐ No ☐ Unknown
☐ *Neisseria meningitidis (specify serogroup if known):*_____

4. Specify the site(s) in which the pathogen was identified **(check all that apply)**:

☐ Blood ☐ Pleural fluid ☐ Endotracheal aspirate
☐ Cerebrospinal fluid (CSF) ☐ Sputum

Please specify any other sterile sites not listed above:_____

5. If other pathogens were isolated from sterile sites **within 2 days of hospital admission**, please list below and specify first culture date and sterile site in which pathogen was identified:_____

Use of Statins (cholesterol lowering medicine)

1. Was the patient taking a statin *before* hospital admission? (**check only one)** ☐ Yes ☐ No ☐ Unknown

a If **YES,** specify name of statin **(enter code)**: _____

2. Did the patient receive statins any time *during* hospitalization? (**check only one)** ☐ Yes ☐ No ☐ Unknown

a If **YES,** specify name of statin **(enter code):** _____

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Treatment of Influenza

1. Did the patient receive treatment with an antiviral medication for influenza at any time during the course of this illness? ☐ Yes ☐ No

   a. If **YES,** indicate which antiviral medication was used for treatment:

   ☐ Amantadine (Symmetrel) ☐ Zanamivir (Relenza) ☐ Rimantadine (Flumadine)

   ☐ Oseltamivir (Tamiflu) ☐ Unknown

   b. Was antiviral treatment started before hospital admission? ☐ Yes ☐ No ☐ Unknown

   c. Indicate antiviral treatment start date: ____-____-_____ (MM-DD-YYYY) ☐ Unknown

From the Discharge Summary

1. Was this patient admitted to an intensive care unit (ICU)? ☐ Yes ☐ No

2. Did the patient have any of the following diagnoses at discharge (**check all that apply**)?

Pneumonia	☐Yes	☐No	Stroke (CVA)	☐Yes	☐No
Acute encephalopathy/encephalitis	☐Yes	☐No			

3. What was the outcome of the patient?

   ☐ Died

   ☐ Alive

   a) **If discharged alive**, please indicate to where:

   ☐ Home

   ☐ Other hospital

   ☐ Long-term care facility / rehabilitation center

   ☐ Hospice

   ☐ Other

   ☐ Unknown

Case Identification Method

1. What is the case identification method (**check only one)**?

   ☐ Initial Surveillance ☐ Discharge data audit

   If Initial Surveillance, specify case finding source (**check all that apply**): ☐ Hospital log ☐ Laboratory list ☐ Reportable disease ☐ Discharge Database

   If other case finding sources were used, please list: _____

Influenza Vaccination History

1. Did the patient receive any **influenza vaccine** during fall or winter of the current influenza season (i.e., at least 2 weeks prior to hospitalization)? ☐ Yes ☐ No ☐ Unknown

2. If **YES,** please specify vaccine type:

   ☐ *Injected* vaccine --Trivalent inactivated influenza vaccine (TIV)

   ☐ *Nasal spray* -- Live-attenuated influenza vaccine (LAIV)

   ☐ Unknown

3. What was the source of vaccination history (**check all that apply**)? ☐ Medical chart ☐ Primary care provider ☐ Interview

   a) If vaccination history obtained by phone interview, specify source of interview: ☐ Patient ☐ Proxy Specify relationship (**enter code**): _____

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COMMENTS: _____