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)

6a. Date of Birth:	7. Sex:	8. Ethnicity:	9. Race (**check all that apply**):
_____-_____-_____ (MM-DD-YYYY) 6b. Age: ____years ____ months	☐ Male ☐ Female	☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Not Specified	☐ 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

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 Cerebal Palsy)
(Specify) _____

☐ Immunosuppressive condition
(Specify)_____

☐ Seizure disorder

☐ History of febrile seizures

☐ Premature (gestational age <37 weeks at birth for patients <2 yrs of age)

(Specify gestational age at birth, in weeks): _____ _____ ☐ Unknown

☐ Developmental delay

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

☐ Long-term aspirin therapy

☐ Abnormality of the upper airway
(Specify) _____

Tests, Procedures, and Interventions during the Hospital Stay

1. Chest X-Ray (any during admission)	☐ Yes	☐ No	3. Extracorporeal Membrane Oxygenation (ECMO or 'on bypass')	☐ Yes	☐ No
a) If **YES**, was there an infiltrate or consolidation?	☐ Yes	☐ No	4. CT Scan/MRI of head or brain	☐ Yes	☐ No
2. Mechanical ventilation	☐ Yes	☐ No	a) If **YES**, were there any neurologic abnormalities?	☐ 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 meningitides (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, please list below and specify first culture date and sterile site in which pathogen was identified:

_____

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	Bronchiolitis	☐Yes	☐No	Encephalopathy/encephalitis	☐Yes	☐No
Seizures	☐Yes	☐No	Reye's syndrome	☐Yes	☐No	Hemophagocytic Syndrome	☐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: _____

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 (**check all that apply**):
   - ☐ *Injected* vaccine --Trivalent inactivated influenza vaccine (TIV)
   - ☐ *Nasal spray* -- Live-attenuated influenza vaccine (LAIV)
   - ☐ *Unknown*

   a) Indicate number of doses: ☐ 1 ☐ 2 ☐ Unknown

   b) For each dose, specify the date given 1) _____-_____-_____ (MM-DD-YYYY)

   2) _____-_____-_____ (MM-DD-YYYY)
3. Did the patient receive any **influenza vaccine** in previous seasons? ☐ Yes ☐ No ☐ Unknown
4. Did the patient receive **pneumococcal conjugate vaccine** at any age (for children born in or after 1998)? ☐ Yes ☐ No ☐ Unknown

   a) **If YES**, please complete the list below.

Dose	Date Given (MM-DD-YYYY)
1	_____-_____-_____
2	_____-_____-_____
3	_____-_____-_____
4	_____-_____-_____

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

COMMENTS:

_____