Form Approv
OMB No. 0920-08A
Exp. Date xx/xx/20

Patient Identifiers and Other Information

Last Name:	First Name:	Spouse's Name:	
Phone No.:	Chart Number:	Additional Numeric ID:	Additional Numeric ID:
Address:		City:	Zip:

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:	8. Sex:	9. Ethnicity:	10. Race (**check all that apply**):
_____-_____-_____ (MM-DD-YYYY)	☐ Male ☐ Female	☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Not Specified	☐ White ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islanc ☐ American Indian or Alaska Native ☐ 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

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

3. Hospital/lab/office ID where positive flu test was performed (If done in doctor's office, use the code **MDTST)**: _____ _____ _____ _____ __

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

5. Influenza virus identification (**check only one type**): ☐ Influenza A ☐ Influenza B ☐ Type unknown

a) If **Influenza A subtype**, please specify if known: _____

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)
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 gestational age in weeks): ____ ____

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
☐ Cerebrospinal fluid (CSF)
☐ Pleural fluid

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):** _____

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

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? ☐ 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**): ___