Antiviral-Resistant Influenza Infection Case Report Form

Form Approved OMB No. 0920-0004 Exp. Date 8/31/2014

I. Specimen Information							
		Reason for Antiviral Resistance Test:		Specimen Type:			
State Lab Specimen ID	Requeste		ed for Clinical Indication	☐ Nasopharyngeal (NP) Swab			
Specimen Collection State		☐ Surveilla	nce	☐ Nasal swab			
Patient County of residence		□ Other		☐ Oropharyngeal Swab			
Patient State of residence		Date of Specimen Collection:		☐ Bronchoalveolar Lavage			
		/ .		□ Other			
II. Basic Information If information is from patient interview please READ: I'm going to ask you for some information about yourself (your child) and your (the child's) illness. To help you remember, I am going to tell you the date that your nose/ throat swab was taken to test for flu (use specimen collection date in section I). Please feel free to look at a calendar to help you remember dates. I can wait until you find one.							
Age: □ yrs □ months	Race:		Illness History:	Patient Outcome:			
Sex: ☐ Male ☐ Female	☐ American Indian/ A	Alaska	Date of illness onset:	☐ At Home			
Sex: Male Female	Native		//	☐ At Extended Care Facility			
Ethnicity:	☐ Asian or Pacific Isl		Hospitalized for illness?	☐ Currently Hospitalized			
☐ Hispanic or Latino	☐ Black or African Ar	merican	□Yes	☐ Dead (Was it influenza-related?			
☐ Not Hispanic or Latino	☐ White		□No	□Yes □ No □ Unknown)			
			□Unknown	□ Unknown			
III. Pre-existing Medical Conditions							
Did a doctor ever tell you that you (your child) had any of the following conditions? (Please check all that apply) □ Immunosuppressive condition (complete section IX), □ Chronic Heart Disease, specify:							
			Chronic Liver Disease, specify:				
☐ Chronic kidney disease			Morbid obesity: Height				
☐ Asthma			Other Condition, specify:				
☐ Chronic lung disease (non-asthma), specify If			female aged ≥16 years, were you pregnant at time of specimen				
	collection: ☐ Yes ☐ No ☐ Unknown Trimester						
IV. Hospitalized Patient Info	rmation (skip to secti	ion V if patie	nts is not hospitalized)				
Date of hospital admission: _		_	Date of hospital discharge:	//			
Reason for Hospital Admission: ☐ Respiratory Illness ☐ Other, specify:							
During hospitalization, was patient:							
In Intensive Care Unit?	Mechanically Ve	entilated?	On Vasopressors?	Renal Failure requiring Dialysis?			
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐	□ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown			
V. Influenza Antiviral Medica	tion History						
Received influenza antiviral medications including oseltamivir (Tamiflu®) or zanamivir (Relenza®)?							
☐ Yes ☐ No (skip to section VI) ☐ Unknown (skip to section VI)							
If yes, Please check all below that apply:							

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0004).

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CDC ID (CDC use only): _____

□ Oseltamivir (Tamiflu) Dose: □ 75mg □ Other Frequency: □ QD □ BID □ Other Indication: □ Treatment □ Prevention Location: □ Outpatient □ Inpatient Start Date:// End Date://	□ Zanamivir (Relenza) Dose: □ 10mg □ Other Route: □ Inhaled □ IV (experimental) Frequency: □ QD □ BID □ Other Indication: □ Treatment □ Prevention Location: □ Outpatient □ Inpatient Start Date:// End Date://	□ Additional/other Agent Name: Dose: Route: □ Oral □ IV □ Inhaled Frequency: □ BID □ Other Indication: □ Treatment □ Prevention Location: □ Outpatient □ Inpatient Start Date:// End Date://				
Patient finished all of the pills (or suspension)? ☐ Yes ☐ No ☐ Unknown						
Information on antiviral treatment is from ☐ medical record ☐ self report						
Comments about antiviral therapy: (e.g. other courses of antiviral treatment, reasons for poor compliance, etc.)						
VI. Influenza Vaccine History						
Did you (your child) receive the influenza vaccine this year? ☐ Yes ☐ No ☐ Unknown						
VII. Transmission History						
At the time you (your child) became ill, reside?	☐ Multi-Family Housir	_				
2. How many people live in your househo	· -	-				
2. How many people live in your household? [a household is defined as the place where you regularly sleep and eat] 3. During the week before illness, did anyone else in the household have flu or a respiratory illness? If yes, how many? If Yes, Did anyone else other than you in the household get a diagnosis of flu? If yes, how many? Unknown If yes, how many?						
During the week before illness, did any receive any antiviral medications?	one else in the household ☐ Yes (☐ for t☐ No☐ Unknown	reatment □ for prevention)				
If yes, What was the name of the antivi		elenza □Unknown □Other specify				
If yes, Where did you travel to? Count	sidence area during the 7 days prior to illness? try state city/town to//					
If the patient is a child, university studen section.	ol/residency also sick at the same time as your school/ reside?	ollowing questions, if not, skip to the next (the child's) flu illness?				

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	☐ Yes ☐ No ☐ Unknown ☐ Yes ☐ No ☐	Any immunosuppressive therapy during the $\underline{\text{year}}$ prior to influenza specimen collection: \square Yes \square No \square Unknown				
☐ Solid Tumor Malignancy: Speci	ify Type (s):	Steroids (Systemic)	Anti-rejection Agents			
1	nosis Date:	Dose	☐ Tacrolimus			
	emotherapy:	Route	☐ Sirolimus			
☐ Hematologic Malignancy: Spec	ify Type (s):	Start Date	☐ Mycophenolate Mofetil			
Diag	nosis Date:	Duration	☐ Anti-thymocyte Globulin			
Date most recent ch	emotherapy:	Antibody Based Agents	Chemotherapeutic Agents			
☐ Receipt of Stem Cell Transplant	t	☐ Alemtuzumab	☐ Cyclophosphamide			
Specify Type (s):	Date:	☐ Basiliximab	☐ Methotrexate			
Descript of Solid Organ Transple		☐ Daclizumab	☐ Fludarabine			
☐ Receipt of Solid Organ Transpla		☐ Trastuzumab	□ Imatinib			
Specify Type (s):	Date:	☐ Rituximab	Chemotherapy Regimens (e.g.			
☐ Autoimmune Disorder		□ Infliximab	CHOP)			
Describe: Dia	agnosis Date:	□ OKT-3				
		Immunosuppressants	Agents not mentioned above			
☐ Other condition (Lupus, Rheum	•	☐ Cyclosporine	G			
Describe: Dia	agnosis Date:	☐ Azathioprine				
Dates of most recent immunosuppre	essive therapy:	. □ Leflunomide				
Results of CBC closest to time of influenza testing (preferably within 24 hours): Total White Blood Cell Count: Absolute Neutrophil Count: Absolute Lymphocyte Count:						
IX. Additional Comments						
Y Sandar Information						
X. Sender Information						
	Name:	Date of Survey Completion: _				