

Antiviral-Resistant Influenza Infection Case Report Form

Form Approved
OMB No. 0920-0004
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I. Specimen Information			
State Lab Specimen ID _____ Specimen Collection State _____ Patient County of residence _____ Patient State of residence _____	Reason for Antiviral Resistance Test: <input type="checkbox"/> Requested for Clinical Indication <input type="checkbox"/> Surveillance <input type="checkbox"/> Other _____	Specimen Type: <input type="checkbox"/> Nasopharyngeal (NP) Swab <input type="checkbox"/> Nasal swab <input type="checkbox"/> Oropharyngeal Swab <input type="checkbox"/> Bronchoalveolar Lavage <input type="checkbox"/> Other _____	
II. Basic Information <i>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.</i>			
Age: ___ □ yrs □ months Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Race: <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White	Illness History: Date of illness onset: ___/___/_____ Hospitalized for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Patient Outcome: <input type="checkbox"/> At Home <input type="checkbox"/> At Extended Care Facility <input type="checkbox"/> Currently Hospitalized <input type="checkbox"/> Dead (Was it influenza-related?) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> 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)			
<input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Chronic kidney disease <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic lung disease (non-asthma), specify _____	<input type="checkbox"/> Immunosuppressive condition (complete section IX), <input type="checkbox"/> Chronic Heart Disease, specify: _____ <input type="checkbox"/> Chronic Liver Disease, specify: _____ <input type="checkbox"/> Morbid obesity: Height _____ Weight _____ <input type="checkbox"/> Other Condition, specify: _____ If female aged ≥16 years, were you pregnant at time of specimen collection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Trimester _____		
IV. Hospitalized Patient Information (skip to section V if patients is not hospitalized)			
Date of hospital admission: ___/___/_____		Date of hospital discharge: ___/___/_____	
Reason for Hospital Admission: <input type="checkbox"/> Respiratory Illness <input type="checkbox"/> Other, specify: _____			
During hospitalization, was patient:			
In Intensive Care Unit? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Mechanically Ventilated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	On Vasopressors? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Renal Failure requiring Dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
V. Influenza Antiviral Medication History			
Received influenza antiviral medications including oseltamivir (Tamiflu®) or zanamivir (Relenza®)? <input type="checkbox"/> Yes <input type="checkbox"/> No (skip to section VI) <input type="checkbox"/> 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).

