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 ______________	☐ Requested for Clinical Indication	☐ Nasopharyngeal (NP) Swab
Specimen Collection State ______________	☐ Surveillance	☐ 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/ Alaska Native	Date of illness onset: __ __/__ __/__ __ __ __	☐ At Home
Ethnicity:	☐ Asian or Pacific Islander	Hospitalized for illness?	☐ At Extended Care Facility
☐ Hispanic or Latino	☐ Black or African American	☐Yes	☐ Currently Hospitalized
☐ Not Hispanic or Latino	☐ White	☐No	☐ Dead (Was it influenza-related? ☐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)

- ☐ Diabetes Mellitus
- ☐ Chronic kidney disease
- ☐ Asthma
- ☐ Chronic lung disease (non-asthma), specify_______
- ☐ Immunosuppressive condition **(complete section IX),**
- ☐ Chronic Heart Disease, specify: ________________
- ☐ Chronic Liver Disease, specify: ________________
- ☐ Morbid obesity: Height _______ Weight _______
- ☐ Other Condition, specify: ________________

If female aged ≥16 years, were you pregnant at time of specimen collection: ☐ Yes ☐ No ☐ 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: ☐ Respiratory Illness ☐ Other, specify:

During hospitalization, was patient:

In Intensive Care Unit?	Mechanically Ventilated?	On Vasopressors?	Renal Failure requiring Dialysis?
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

V. Influenza Antiviral Medication 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).

FAX COMPLETED FORM TO: 404-639-3866 **CDC ID (*CDC use only*):** _______________

☐ **Oseltamivir (Tamiflu)**	☐ **Zanamivir (Relenza)**	☐ **Additional/other Agent**
Dose: ☐ 75mg ☐ Other _______	Dose: ☐ 10mg ☐ Other _______	Name: ______________________
Frequency: ☐ QD ☐ BID ☐ Other _____	Route: ☐ Inhaled ☐ IV (experimental)	Dose: ______________________
Indication: ☐ Treatment ☐ Prevention	Frequency: ☐ QD ☐ BID ☐ Other _____	Route: ☐ Oral ☐ IV ☐ Inhaled
Location: ☐ Outpatient ☐ Inpatient	Indication: ☐ Treatment ☐ Prevention	Frequency: ☐ BID ☐ Other _______
Start Date: __ __/ __ __/ __ __ __ __	Location: ☐ Outpatient ☐ Inpatient	Indication: ☐ Treatment ☐ Prevention
End Date: __ __/ __ __/ __ __ __ __	Start Date: __ __/ __ __/ __ __ __ __	Location: ☐ Outpatient ☐ Inpatient
	End Date: __ __/ __ __/ __ __ __ __	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

1. At the time you (your child) became ill, where did you reside?
   - ☐ Single Family House (1 housing unit in building)
   - ☐ Multi-Family Housing (> 1 unit in building)
   - ☐ Facility (hospital, long term care, nursing home, jail, etc)
   - ☐ University Dorm or boarding school
   - ☐ Other, specify: ______________________________
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? ☐ Yes ☐ No ☐ Unknown
   If yes, how many? ________
   If Yes, Did anyone else other than you in the household get a diagnosis of flu? ☐ Yes ☐ No ☐ Unknown
   If yes, how many? ________
4. During the week before illness, did anyone else in the household receive any antiviral medications? ☐ Yes (☐ for treatment ☐ for prevention) ☐ No ☐ Unknown
   If yes, What was the name of the antiviral agent? ☐ Tamiflu ☐Relenza ☐Unknown ☐Other specify______
5. Did you travel outside of your typical residence area during the 7 days prior to illness? ☐ Yes ☐ No ☐ Unknown
   If yes, Where did you travel to? Country__________ state______ city/town_____________
   Dates of travel? __ __/ __ __/ __ __ __ __ to __ __/ __ __/__ __ __ __

If the patient is a child, university student or living in a facility (e.g. LTCF), ask the following questions, if not, skip to the next section.

6. Were others at your (your child's) school/residency also sick at the same time as your (the child's) flu illness?
   ☐ Yes ☐ No ☐ DK
   If yes, where do you (your child) go to school/ reside? ________________________________

VIII. Immunosuppression Details (skip to section IX if not immunosuppressed) (check all that apply)

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☐ **HIV/AIDS:** CD4 count ≤ 200: ☐ Yes ☐ No ☐ Unknown
On antiretroviral therapy: ☐ Yes ☐ No ☐ Unknown

☐ **Solid Tumor Malignancy:** Specify Type (s):
Diagnosis Date: ____________
Date most recent chemotherapy: ____________

☐ **Hematologic Malignancy:** Specify Type (s):
Diagnosis Date:____________
Date most recent chemotherapy: ____________

☐ Receipt of **Stem Cell Transplant**
Specify Type (s): Date: ____________

☐ Receipt of **Solid Organ Transplant**
Specify Type (s): Date:____________

☐ **Autoimmune Disorder**
Describe: Diagnosis Date: ____________

☐ **Other condition** (Lupus, Rheumatoid Arthritis, Crohns, etc)
Describe: Diagnosis Date: ____________

Dates of most recent immunosuppressive therapy:

Any immunosuppressive therapy during the year prior to influenza specimen collection: ☐ Yes ☐ No ☐ Unknown

Steroids (Systemic)
Dose ______________
Route ______________
Start Date ___________
Duration ____________

Antibody Based Agents
☐ Alemtuzumab
☐ Basiliximab
☐ Daclizumab
☐ Trastuzumab
☐ Rituximab
☐ Infliximab
☐ OKT-3

Immunosuppressants
☐ Cyclosporine
☐ Azathioprine
☐ Leflunomide

Anti-rejection Agents
☐ Tacrolimus
☐ Sirolimus
☐ Mycophenolate Mofetil
☐ Anti-thymocyte Globulin

Chemotherapeutic Agents
☐ Cyclophosphamide
☐ Methotrexate
☐ Fludarabine
☐ Imatinib

Chemotherapy Regimens (e.g. CHOP)
____
____

Agents not mentioned above
____
____

Results of CBC closest to time of influenza testing (preferably within 24 hours): Date of CBC: __ __/ __ __/ __ __ __ __
Total White Blood Cell Count: ______ Absolute Neutrophil Count: ______ Absolute Lymphocyte Count: ______

IX. Additional Comments

X. Sender Information

First Name:	Last Name:	Date of Survey Completion: __ __/ __ __/ __ __ __ __
Institution Name:	Email Address:	Telephone Number: