Form Approved

OMB No. 0920-XXXX

Exp. Date xx/xx/xxxx

|  |
| --- |
| **A. Patient Data – THIS INFORMATION IS NOT SENT TO CDC** |
| **Last Name:** | **First Name:** | **Phone Number 1:** | **Phone Number 2:** |
| **Emergency Contact 1:** | **Emergency Contact 2:** |
| **Street Address:**  | **City:** | **Zip:** |
| **Chart Number:** | **Primary Provider** **Name:** | **Provider Phone****Number:** | **Provider Fax****Number:** |
| **Site Use 1:** | **Site Use 2:**  |
| **Site Use 3:** | **Site Use 4:** |

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| **B. Reporter Information** |
| **1. Reporter Name:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **2. Date Reported:** \_\_\_\_/ \_\_\_\_/ \_\_\_\_ |
| **C. Enrollment Information** |
| **1. Case Classification:** | 🞎 Prospective Surveillance | **2. State:** | **3. County:** |
|  | 🞎 Audit |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **4. Case Type:**  | 🞎 Pediatric | **5. Date of Birth:** | **6. Age:** | 🞎 Years | 🞎 Days (if < 1 month) | **7. Sex:** | 🞎 Male |
|  | 🞎 Adult | \_\_\_\_/ \_\_\_\_/ \_\_\_\_ | \_\_\_\_\_\_\_\_\_ | 🞎 Months (if < 1 yr) |  |  | 🞎 Female |
| **8. Race:** | 🞎 White | 🞎 Black or African American | 🞎 Asian/Pacific Islander | **9. Ethnicity:** | 🞎 Hispanic or Latino |
|  | 🞎 American Indian or Alaska Native | 🞎 Multiracial | 🞎 Not specified | 🞎 Non-Hispanic or Latino | 🞎 Not Specified |
| **10. Hospital ID Where**  **Patient Treated:** |  | **10a. Admission Date:** |  | **10b. Discharge Date:** |  |
| \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_ | \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_ |
| **11. Was patient transferred from another hospital?** | 🞎 Yes  | 🞎 No | 🞎 Unknown |
| **11a. Transfer Hospital ID:**  |  | **11b. Transfer Hospital**  |  | **11c. Transfer Date:** |  |
| \_\_\_\_\_\_\_\_\_\_\_ |  **Admission Date:** | \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_ | \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_ |
| **12. Was patient a resident of an institutional setting or other chronic care facility prior to**  **hospitalization (e.g., nursing home, prison, long-term care facility)?** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **12a. If yes, indicate TYPE of facility**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **12b. If yes, indicate NAME of facility**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **13. Does patient work in the healthcare industry?** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **D. Influenza Testing Results** |
| **1. Test 1:** | 🞎 Rapid | 🞎 RT-PCR | 🞎 Viral Culture | 🞎 Serology | 🞎 Fluorescent Antibody | 🞎 Method Unknown/Note Only |
| **1a. Result:** | 🞎 Flu A (not subtyped) | 🞎 Flu B | 🞎 Flu A & B | 🞎 Flu A/B (Not Distinguished) |
|  | 🞎 2009 H1N1 | 🞎 H1, Seasonal | 🞎 H1, Unspecified | 🞎 H3 | 🞎 Flu A, Unsubtypable |
|  | 🞎 Negative | 🞎 Unknown | 🞎 Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **1b. Specimen collection date:** \_\_\_/\_\_\_/ \_\_\_ | **1c. Testing facility ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **1d. Specimen ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **2. Test 2:** | 🞎 Rapid | 🞎 RT-PCR | 🞎 Viral Culture | 🞎 Serology | 🞎 Fluorescent Antibody | 🞎 Method Unknown/Note Only |
| **2a. Result:** | 🞎 Flu A (not subtyped) | 🞎 Flu B | 🞎 Flu A & B | 🞎 Flu A/B (Not Distinguished) |
|  | 🞎 2009 H1N1 | 🞎 H1, Seasonal | 🞎 H1, Unspecified | 🞎 H3 | 🞎 Flu A, Unsubtypable |
|  | 🞎 Negative | 🞎 Unknown | 🞎 Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **2b. Specimen collection date:** \_\_\_/\_\_\_/ \_\_\_ | **2c. Testing facility ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **2d. Specimen ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **3. Test 3:** | 🞎 Rapid | 🞎 RT-PCR | 🞎 Viral Culture | 🞎 Serology | 🞎 Fluorescent Antibody | 🞎 Method Unknown/Note Only |
| **3a. Result:** | 🞎 Flu A (not subtyped) | 🞎 Flu B | 🞎 Flu A & B | 🞎 Flu A/B (Not Distinguished) |
|  | 🞎 2009 H1N1 | 🞎 H1, Seasonal | 🞎 H1, Unspecified | 🞎 H3 | 🞎 Flu A, Unsubtypable |
|  | 🞎 Negative | 🞎 Unknown | 🞎 Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **3b. Specimen collection date:** \_\_\_/\_\_\_/ \_\_\_ | **3c. Testing facility ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **3d. Specimen ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **4. Test 4:** | 🞎 Rapid | 🞎 RT-PCR | 🞎 Viral Culture | 🞎 Serology | 🞎 Fluorescent Antibody | 🞎 Method Unknown/Note Only |
| **4a. Result:** | 🞎 Flu A (not subtyped) | 🞎 Flu B | 🞎 Flu A & B | 🞎 Flu A/B (Not Distinguished) |
|  | 🞎 2009 H1N1 | 🞎 H1, Seasonal | 🞎 H1, Unspecified | 🞎 H3 | 🞎 Flu A, Unsubtypable |
|  | 🞎 Negative | 🞎 Unknown | 🞎 Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **4b. Specimen collection date:** \_\_\_/\_\_\_/ \_\_\_ | **4c. Testing facility ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **4d. Specimen ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

Public reporting burden of this collection of information is estimated to average 15 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-xxxx).

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| **E. Admission and Patient History** |
| **1. Was patient discharged from any hospital within one week prior to the current admission date?** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **2. Reason for current admission (Check all that apply):** |
|  | 🞎 Acute respiratory illness | 🞎 Asthma and/or COPD exacerbation | 🞎 Pneumonia |
|  | 🞎 Other respiratory or cardiac conditions | 🞎 Other, neither respiratory nor cardiac conditions | 🞎 Unknown |
| **3. Date of onset of acute illness**  **resulting in hospitalization:** |  | 🞎 Unknown | **4. Date of onset of respiratory**  **symptoms:** |  | 🞎 Unknown |
| \_\_\_\_/ \_\_\_\_/ \_\_\_\_ | \_\_\_\_/ \_\_\_\_/ \_\_\_\_ |
| **5. Body Mass** **Index:** |  | **6. Height:** |  | 🞎 Inches🞎 Cm | 🞎 Height  Unknown | **7. Weight:** |  | 🞎 Lbs🞎 Kg | 🞎 Weight  Unknown |
| \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ |
| **8. Did patient have any of the following pre-existing medical conditions? Check all that apply.** | 🞎 Yes | 🞎 No | 🞎 Unknown |
|  |
| **8a. Chronic Lung Disease** | 🞎 Yes | 🞎 No/Unknown | **8f. Chronic Metabolic Disease** | 🞎 Yes | 🞎 No/Unknown |
|  | 🞎 Asthma/Reactive airway disease |  | 🞎 Diabetes |
|  | 🞎 Cystic fibrosis |  | 🞎 Thyroid dysfunction |
|  | 🞎 Emphysema/COPD |  | 🞎 Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | 🞎 Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | **8g. Blood disorders/Hemoglobinopathy** | 🞎 Yes | 🞎 No/Unknown |
| **8b. Cardiovascular Disease** | 🞎 Yes | 🞎 No/Unknown |  | 🞎 Sickle cell disease |
|  | 🞎 Atherosclerotic cardiovascular disease (ASCVD)  |  | 🞎 Splenectomy/Asplenia |
|  | 🞎 Cerebral vascular incident/Stroke  |  | 🞎 Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | 🞎 Congenital heart disease |  |
|  | 🞎 Coronary artery disease (CAD) | **8h. Renal Disease** | 🞎 Yes | 🞎 No/Unknown |
|  | 🞎 Heart failure/CHF |  | 🞎 Chronic kidney disease/chronic renal insufficiency |
|  | 🞎 Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | 🞎 End stage renal disease/Dialysis  |
|  |  | 🞎 Glomerulonephritis |
| **8c. Neurologic disorder** | 🞎 Yes | 🞎 No/Unknown |  | 🞎 Nephrotic syndrome |
|  | 🞎 Cerebral palsy |  | 🞎 Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | 🞎 Cognitive dysfunction |  |
|  | 🞎 Dementia | **8i. History of Guillain-Barré Syndrome** | 🞎 Yes | 🞎 No/Unknown |
|  | 🞎 Developmental delay |  |
|  | 🞎 Down syndrome | **8j. Other** | 🞎 Yes | 🞎 No/Unknown |
|  | 🞎 Plegias/Paralysis |  | 🞎 Alcohol abuse |
|  | 🞎 Seizure/Seizure disorder |  | 🞎 Current smoker |
|  | 🞎 Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | 🞎 Liver disease |
|  |  | 🞎 Morbidly obese (ADULTS ONLY) |
| **8d. Neuromuscular disorder** | 🞎 Yes | 🞎 No/Unknown |  | 🞎 Mitochondrial disorder |
|  | 🞎 Duchenne muscular dystrophy |  | 🞎 Obese |
|  | 🞎 Muscular dystrophy |  | 🞎 Pregnant |
|  | 🞎 Multiple sclerosis |  | If pregnant, specify gestational age in weeks: \_\_\_\_\_\_\_\_\_\_\_ |
|  | 🞎 Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | 🞎 Unknown gestational age |
|  |  | 🞎 Post-partum (two weeks or less) |
| **8e. Immunocompromised Condition** | 🞎 Yes | 🞎 No/Unknown |  | 🞎 Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | 🞎 AIDS or CD4 count < 200 |  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  | 🞎 Bone marrow transplant |  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  | 🞎 Cancer diagnosis in last 12 months |  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  | 🞎 Complement deficiency |  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  | 🞎 History of lymphoma or leukemia |  |  |
|  | 🞎 HIV Infection | 8k. PEDIATRIC CASES ONLY |
|  | 🞎 Hodgkin’s disease/lymphoma | **Abnormality of upper airway** | 🞎 Yes | 🞎 No/Unknown |
|  | 🞎 Immunoglobulin deficiency | **History of febrile seizures** | 🞎 Yes | 🞎 No/Unknown |
|  | 🞎 Immunosuppressive therapy | **Long-term aspirin therapy** | 🞎 Yes | 🞎 No/Unknown |
|  | 🞎 Multiple myeloma | **Premature** | 🞎 Yes | 🞎 No/Unknown |
|  | 🞎 Organ transplant | (gestation age < 37 weeks at birth for patients < 2yrs) |
|  | 🞎 Steroid therapy |  | If yes, specify gestation age at birth in weeks: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | 🞎 Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | 🞎 Unknown gestational age at birth |
|  |
| **F. Test, Procedures and Interventions During Hospital Stay** |
| **1. Did patient receive mechanical ventilation?** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **2. Did patient receive extracorporeal membrane**  **oxygenation (ECMO or ‘on bypass’)?** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **G. Bacterial Pathogens** |
| **1. Was there culture confirmation of a bacterial infection *within 3 days* (collection date) of admission?** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **2. If yes, specify:** |
| **2a. Pathogen 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **2b. Date of culture:** \_\_\_\_/ \_\_\_\_/ \_\_\_\_ |
| **2c. If Staphylococcus aureus, specify:** | 🞎 Methicillin resistant (MRSA) | 🞎 Methicillin sensitive (MSSA) | 🞎 Sensitivity unknown |
| **2d. If Haemophilus influenzae, specify if type B:** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **2e. If Neisseria meningitidis, specify serogroup:** | 🞎 B | 🞎 C | 🞎 Y | 🞎 Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 Unknown |
| **2f. Site where pathogen identified:** | 🞎 Blood | 🞎 Cerebrospinal fluid (CSF) | 🞎 Bronchoalveolar lavage (BAL) | 🞎 Sputum |
| 🞎 Endotracheal aspirate | 🞎 Pleural fluid | 🞎 Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **3. If multiple pathogens identified, specify:** |
| **3a. Pathogen 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **3b. Date of culture:** \_\_\_\_/ \_\_\_\_/ \_\_\_\_ |
| **3c. If Staphylococcus aureus, specify:** | 🞎 Methicillin resistant (MRSA) | 🞎 Methicillin sensitive (MSSA) | 🞎 Sensitivity unknown |
| **3d. If Haemophilus influenzae, specify if type B:** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **3e. If Neisseria meningitidis, specify serogroup:** | 🞎 B | 🞎 C | 🞎 Y | 🞎 Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 Unknown |
| **3f. Site where pathogen identified:** | 🞎 Blood | 🞎 Cerebrospinal fluid (CSF) | 🞎 Bronchoalveolar lavage (BAL) | 🞎 Sputum |
| 🞎 Endotracheal aspirate | 🞎 Pleural fluid  | 🞎 Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **H. Viral Pathogens** |
| **1. Was patient tested for any of the following viral pathogens *within 3 days* of admission?** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| 1a. Respiratory syncytial virus/RSV | 🞎 Yes, positive | 🞎 Yes, negative | 🞎 Not tested/Unknown | **Date**: \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| 1b. Adenovirus | 🞎 Yes, positive | 🞎 Yes, negative | 🞎 Not tested/Unknown | **Date**: \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| 1c. Parainfluenza 1 | 🞎 Yes, positive | 🞎 Yes, negative | 🞎 Not tested/Unknown | **Date**: \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| 1d. Parainfluenza 2 | 🞎 Yes, positive | 🞎 Yes, negative | 🞎 Not tested/Unknown | **Date**: \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| 1e. Parainfluenza 3 | 🞎 Yes, positive | 🞎 Yes, negative | 🞎 Not tested/Unknown | **Date**: \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| 1f. Human metapneumovirus | 🞎 Yes, positive | 🞎 Yes, negative | 🞎 Not tested/Unknown | **Date**: \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| 1g. Rhinovirus | 🞎 Yes, positive | 🞎 Yes, negative | 🞎 Not tested/Unknown | **Date**: \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| 1h. Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 Yes, positive | 🞎 Yes, negative | 🞎 Not tested/Unknown | **Date**: \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| **I. Influenza Treatment** |
| **1. Did the patient receive treatment with an antiviral medication for**  **influenza at any time during the course of this illness?** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **1a. If yes, indicate which antiviral medication(s) were used, or check unknown:** |  🞎 Antiviral Medication(s) Unknown |
|  | **Series 1** | **Series 2** |
| **Treatment** | **Start Date** | **End Date** | **Frequency and Dose** | **Start Date** | **End Date** | **Frequency and Dose** |
| 🞎 Amantadine  (Symmetrel) |  |  |  |  |  |  |
|  |  |  |  |  |  |
| 🞎 Rimantadine  (Flumadine) |  |  |  |  |  |  |
|  |  |  |  |  |  |
| 🞎 Zanamivir  (Relenza) |  |  | Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | 🞎 QD 🞎 BID 🞎 TID |  |  | 🞎 QD 🞎 BID 🞎 TID |
| 🞎 Oseltamivir  (Tamiflu) |  |  | Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | 🞎 QD 🞎 BID 🞎 TID |  |  | 🞎 QD 🞎 BID 🞎 TID |
| 🞎 Other, specify: |  |  | Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  | 🞎 QD 🞎 BID 🞎 TID |  |  | 🞎 QD 🞎 BID 🞎 TID |
| **2. Additional Treatment Comments:** |
| **J. Chest Radiograph During Hospital Stay** |
| **1. Was a chest x-ray taken *within 3 days* of admission?** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **2. Were any of these chest x-rays abnormal?** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **2a. Date of first abnormal chest x-ray:** | \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| **2b. For first abnormal chest x-ray, please check all that apply:** |
| 🞎 Report not available | 🞎 Bronchopneumonia/pneumonia | 🞎 Cannot rule out pneumonia |
| 🞎 Air space density/opacity  | 🞎 Consolidation | 🞎 Interstitial infiltrate |
| 🞎 Pleural effusion | 🞎 Single lobar infiltrate | 🞎 Multiple lobar infiltrate (unilateral or bilateral) |
| 🞎 Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **K. Discharge Summary** |
| **1. Was the patient admitted to**  **an intensive care unit (ICU)?** | 🞎 Yes | 🞎 No | **1a. Date of ICU Admission:** | \_\_\_\_/\_\_\_\_/\_\_\_\_ | 🞎 Unknown |
| 🞎 Unknown | **1b. Date of ICU Discharge:** | \_\_\_\_/\_\_\_\_/\_\_\_\_ | 🞎 Unknown |
| **2. Did the patient have any of the following diagnoses at discharge (check all that apply)?** |
| Pneumonia | 🞎 Yes | 🞎 No | 🞎 Unknown | Stroke (CVI) | 🞎 Yes | 🞎 No | 🞎 Unknown |
| Guillain-Barré syndrome | 🞎 Yes | 🞎 No | 🞎 Unknown | Acute myocarditis | 🞎 Yes | 🞎 No | 🞎 Unknown |
| Acute encephalopathy/ encephalitis | 🞎 Yes | 🞎 No | 🞎 Unknown | Acute respiratory distress syndrome (ARDS) | 🞎 Yes | 🞎 No | 🞎 Unknown |
| Seizures | 🞎 Yes | 🞎 No | 🞎 Unknown | Bronchiolitis | 🞎 Yes | 🞎 No | 🞎 Unknown |
| Reye’s syndrome | 🞎 Yes | 🞎 No | 🞎 Unknown | Hemophagocytic syndrome | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **3. What was the outcome of the patient?** | 🞎 Alive | 🞎 Deceased | 🞎 Unknown |
| **3a. If discharged alive, please indicate to where:** |
| 🞎 Home | 🞎 Other hospital | 🞎 Hospice | 🞎 Long-term care facility | 🞎 Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 Unknown |
| **4. If patient was pregnant on admission, indicate pregnancy status at discharge:** | 🞎 Still pregnant | 🞎 No longer pregnant | 🞎 Unknown |
| **4a. If patient was pregnant on admission but no longer pregnant at discharge, indicate pregnancy outcome at discharge:** |
| 🞎 Miscarriage | 🞎 Ill newborn | 🞎 Newborn died | 🞎 Healthy newborn | 🞎 Abortion | 🞎 Unknown |
| **5. Additional notes regarding discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **L. ICD-9 Discharge Diagnoses** |
| 1.  | 4.  | 7.  |
| 2.  | 5.  | 8.  |
| 3.  | 6.  | 9.  |
| **M. Vaccination History**  |
| **For mothers of patients < 6 months** |
| **1. Did patient’s mother receive the influenza vaccine during fall or winter of the current**  **influenza season?** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **1a. If yes, specify mother’s vaccine type:** | 🞎 Injected Vaccine – Trivalent inactivated influenza vaccine (TIV) | 🞎 Vaccine type unknown |
|  | 🞎 Nasal Spray – Live attenuated influenza vaccine (LAIV) |  |
| **2. Did patient receive the influenza vaccine during fall or winter of the current influenza season**  | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **2a. If yes, specify dosage date information:** | 1) \_\_\_/\_\_\_/\_\_\_ | 2) (Pediatrics Only) \_\_\_/\_\_\_/\_\_\_  |  |
| **2b. If yes, specify patient’s vaccine type:** | 🞎 Injected Vaccine – Trivalent inactivated influenza vaccine (TIV) | 🞎 Vaccine type unknown |
|  | 🞎 Nasal Spray – Live attenuated influenza vaccine (LAIV) |  |
| **2c**. **If patient ≥ 18 years and received injected vaccine (TIV), please specify type:**  | 🞎 Regular IM | 🞎 High dose IM | 🞎 Intradermal | 🞎 TIV type unknown |
| **3. If patient < 9 years, did patient receive any seasonal influenza vaccine in previous seasons?** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **4. Did patient receive any type of pneumococcal vaccine at any age?** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **4a. If yes, please provide dosage date information:** |
| Dose 1 \_\_\_/ \_\_\_/ \_\_\_ | Dose 2 \_\_\_/ \_\_\_/ \_\_\_ | Dose 3 (Pediatrics Only) \_\_\_/ \_\_\_/ \_\_\_ | Dose 4 (Pediatrics Only) \_\_\_/ \_\_\_/ \_\_\_ |
| **4b. If patient ≥ 65 years, was vaccine received within last five years?** | 🞎 Yes | 🞎 No | 🞎 Unknown |
| **5. What is the source of vaccination history (check all that apply)?** |
| 🞎 Medical Chart | 🞎 Vaccine Registry | 🞎 Primary Care Provider | 🞎 Interview | 🞎 Patient Refused/Lost |
| **5a. If vaccination history obtained by phone interview, please specify source of interview:** |
| 🞎 Patient | 🞎 Proxy | If proxy, specify relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **N. Miscellaneous** |
| **1. Case Finding:** | 🞎 Hospital Log | 🞎 Laboratory List | 🞎 Discharge Database | 🞎 Reportable Disease | 🞎 Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_ |
| **2. Additional Comments:** |