

2011-12 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form

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:	

B. Reporter Information	
1. Reporter Name:	2. Date Reported: ___/___/___

C. Enrollment Information			
1. Case Classification: <input type="checkbox"/> Prospective Surveillance <input type="checkbox"/> Audit	2. State: _____	3. County: _____	
4. Case Type: <input type="checkbox"/> Pediatric <input type="checkbox"/> Adult	5. Date of Birth: ___/___/___	6. Age: <input type="checkbox"/> Years <input type="checkbox"/> Days (if < 1 month) <input type="checkbox"/> Months (if < 1 yr)	7. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
8. Race: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Multiracial	<input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Not specified	9. Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Not Specified	
10. Hospital ID Where Patient Treated: _____	10a. Admission Date: ___/___/___	10b. Discharge Date: ___/___/___	
11. Was patient transferred from another hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		11c. Transfer Date: ___/___/___	
11a. Transfer Hospital ID: _____	11b. Transfer Hospital Admission Date: ___/___/___	11c. Transfer 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)?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
12a. If yes, indicate TYPE of facility: _____		12b. If yes, indicate NAME of facility: _____	
13. Does patient work in the healthcare industry? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

D. Influenza Testing Results			
1. Test 1: <input type="checkbox"/> Rapid <input type="checkbox"/> RT-PCR <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology <input type="checkbox"/> Fluorescent Antibody <input type="checkbox"/> Method Unknown/Note Only			
1a. Result: <input type="checkbox"/> Flu A (not subtyped) <input type="checkbox"/> Flu B <input type="checkbox"/> Flu A & B <input type="checkbox"/> Flu A/B (Not Distinguished) <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H1, Seasonal <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> H3 <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____			
1b. Specimen collection date: ___/___/___		1d. Specimen ID: _____	
2. Test 2: <input type="checkbox"/> Rapid <input type="checkbox"/> RT-PCR <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology <input type="checkbox"/> Fluorescent Antibody <input type="checkbox"/> Method Unknown/Note Only			
2a. Result: <input type="checkbox"/> Flu A (not subtyped) <input type="checkbox"/> Flu B <input type="checkbox"/> Flu A & B <input type="checkbox"/> Flu A/B (Not Distinguished) <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H1, Seasonal <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> H3 <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____			
2b. Specimen collection date: ___/___/___		2d. Specimen ID: _____	
3. Test 3: <input type="checkbox"/> Rapid <input type="checkbox"/> RT-PCR <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology <input type="checkbox"/> Fluorescent Antibody <input type="checkbox"/> Method Unknown/Note Only			
3a. Result: <input type="checkbox"/> Flu A (not subtyped) <input type="checkbox"/> Flu B <input type="checkbox"/> Flu A & B <input type="checkbox"/> Flu A/B (Not Distinguished) <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H1, Seasonal <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> H3 <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____			
3b. Specimen collection date: ___/___/___		3d. Specimen ID: _____	
4. Test 4: <input type="checkbox"/> Rapid <input type="checkbox"/> RT-PCR <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology <input type="checkbox"/> Fluorescent Antibody <input type="checkbox"/> Method Unknown/Note Only			
4a. Result: <input type="checkbox"/> Flu A (not subtyped) <input type="checkbox"/> Flu B <input type="checkbox"/> Flu A & B <input type="checkbox"/> Flu A/B (Not Distinguished) <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H1, Seasonal <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> H3 <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____			
4b. Specimen collection date: ___/___/___		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).

2011-12 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form**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 Height Unknown Lbs Weight Unknown
 Cm Kg**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

-
- Asthma/Reactive airway disease
-
-
- Cystic fibrosis
-
-
- Emphysema/COPD
-
-
- Other, specify _____

8f. Chronic Metabolic Disease Yes No/Unknown

-
- Diabetes
-
-
- Thyroid dysfunction
-
-
- Other, specify: _____

8b. Cardiovascular Disease Yes No/Unknown

-
- Atherosclerotic cardiovascular disease (ASCVD)
-
-
- Cerebral vascular incident/Stroke
-
-
- Congenital heart disease
-
-
- Coronary artery disease (CAD)
-
-
- Heart failure/CHF
-
-
- Other, specify _____

8g. Blood disorders/Hemoglobinopathy Yes No/Unknown

-
- Sickle cell disease
-
-
- Splenectomy/Asplenia
-
-
- Other, specify _____

8h. Renal Disease Yes No/Unknown

-
- Chronic kidney disease/chronic renal insufficiency
-
-
- End stage renal disease/Dialysis
-
-
- Glomerulonephritis
-
-
- Nephrotic syndrome
-
-
- Other, specify _____

8c. Neurologic disorder Yes No/Unknown

-
- Cerebral palsy
-
-
- Cognitive dysfunction
-
-
- Dementia
-
-
- Developmental delay
-
-
- Down syndrome
-
-
- Plegias/Paralysis
-
-
- Seizure/Seizure disorder
-
-
- Other, specify: _____

8i. History of Guillain-Barré Syndrome Yes No/Unknown**8j. Other** Yes No/Unknown

-
- Alcohol abuse
-
-
- Current smoker
-
-
- Liver disease
-
-
- Morbidly obese (ADULTS ONLY)
-
-
- Mitochondrial disorder
-
-
- Obese
-
-
- Pregnant
-
- If pregnant, specify gestational age in weeks: _____
-
-
- Unknown gestational age
-
-
- Post-partum (two weeks or less)
-
-
- Other, specify _____

8d. Neuromuscular disorder Yes No/Unknown

-
- Duchenne muscular dystrophy
-
-
- Muscular dystrophy
-
-
- Multiple sclerosis
-
-
- Other, specify: _____

8e. Immunocompromised Condition Yes No/Unknown

-
- AIDS or CD4 count < 200
-
-
- Bone marrow transplant
-
-
- Cancer diagnosis in last 12 months
-
-
- Complement deficiency
-
-
- History of lymphoma or leukemia
-
-
- HIV Infection
-
-
- Hodgkin's disease/lymphoma
-
-
- Immunoglobulin deficiency
-
-
- Immunosuppressive therapy
-
-
- Multiple myeloma
-
-
- Organ transplant
-
-
- Steroid therapy
-
-
- Other, specify _____

8k. PEDIATRIC CASES ONLY**Abnormality of upper airway** Yes No/Unknown**History of febrile seizures** Yes No/Unknown**Long-term aspirin therapy** Yes No/Unknown**Premature** Yes No/Unknown

(gestation age < 37 weeks at birth for patients < 2yrs)

If yes, specify gestation age at birth in weeks: _____

 Unknown gestational age at birth

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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 | <input type="checkbox"/> Yes, positive | <input type="checkbox"/> Yes, negative | <input type="checkbox"/> Not tested/Unknown | Date: ____/____/____ |
| 1b. Adenovirus | <input type="checkbox"/> Yes, positive | <input type="checkbox"/> Yes, negative | <input type="checkbox"/> Not tested/Unknown | Date: ____/____/____ |
| 1c. Parainfluenza 1 | <input type="checkbox"/> Yes, positive | <input type="checkbox"/> Yes, negative | <input type="checkbox"/> Not tested/Unknown | Date: ____/____/____ |
| 1d. Parainfluenza 2 | <input type="checkbox"/> Yes, positive | <input type="checkbox"/> Yes, negative | <input type="checkbox"/> Not tested/Unknown | Date: ____/____/____ |
| 1e. Parainfluenza 3 | <input type="checkbox"/> Yes, positive | <input type="checkbox"/> Yes, negative | <input type="checkbox"/> Not tested/Unknown | Date: ____/____/____ |
| 1f. Human metapneumovirus | <input type="checkbox"/> Yes, positive | <input type="checkbox"/> Yes, negative | <input type="checkbox"/> Not tested/Unknown | Date: ____/____/____ |
| 1g. Rhinovirus | <input type="checkbox"/> Yes, positive | <input type="checkbox"/> Yes, negative | <input type="checkbox"/> Not tested/Unknown | Date: ____/____/____ |
| 1h. Other, specify: _____ | <input type="checkbox"/> Yes, positive | <input type="checkbox"/> Yes, negative | <input type="checkbox"/> 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

Treatment	Series 1			Series 2		
	Start Date	End Date	Frequency and Dose	Start Date	End Date	Frequency and Dose
<input type="checkbox"/> Amantadine (Symmetrel)						
<input type="checkbox"/> Rimantadine (Flumadine)						
<input type="checkbox"/> Zanamivir (Relenza)			Dose: _____ <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID			Dose: _____ <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID
<input type="checkbox"/> Oseltamivir (Tamiflu)			Dose: _____ <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID			Dose: _____ <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID
<input type="checkbox"/> Other, specify: _____			Dose: _____ <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID			Dose: _____ <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID

2. Additional Treatment Comments:

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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:

<input type="checkbox"/> Report not available	<input type="checkbox"/> Bronchopneumonia/pneumonia	<input type="checkbox"/> Cannot rule out pneumonia
<input type="checkbox"/> Air space density/opacity	<input type="checkbox"/> Consolidation	<input type="checkbox"/> Interstitial infiltrate
<input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Single lobar infiltrate	<input type="checkbox"/> Multiple lobar infiltrate (unilateral or bilateral)
<input type="checkbox"/> Other, specify: _____		

K. Discharge Summary

1. Was the patient admitted to an intensive care unit (ICU)? Yes No Unknown

1a. Date of ICU Admission: / / Unknown

1b. Date of ICU Discharge: / / Unknown

2. Did the patient have any of the following diagnoses at discharge (check all that apply)?

Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Stroke (CVI)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Guillain-Barré syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Acute myocarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Acute encephalopathy/encephalitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Acute respiratory distress syndrome (ARDS)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Bronchiolitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Reye's syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Hemophagocytic syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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:



Case ID: __ _ 1 1 1 2 __ _ __ _

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