Form Approved
OMB No. 0920-xxxx
Exp. Date xx/xx/xxxx

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

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: ☐ Prospective Surveillance ☐ Audit **2. State:** _____ **3. County:** _____

4. Case Type: ☐ Pediatric ☐ Adult **5. Date of Birth:** ____/____/____ **6. Age:** _____ ☐ Years ☐ Months (if < 1 yr) ☐ Days (if < 1 month) **7. Sex:** ☐ Male ☐ Female

8. Race: ☐ White ☐ Black or African American ☐ Asian/Pacific Islander ☐ American Indian or Alaska Native ☐ Multiracial ☐ Not specified **9. Ethnicity:** ☐ Hispanic or Latino ☐ 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 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)? ☐ 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:** _____

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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
- ☐ Asthma/Reactive airway disease
- ☐ Cystic fibrosis
- ☐ Emphysema/COPD
- ☐ 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 _____

8c. Neurologic disorder ☐ Yes ☐ No/Unknown
- ☐ Cerebral palsy
- ☐ Cognitive dysfunction
- ☐ Dementia
- ☐ Developmental delay
- ☐ Down syndrome
- ☐ Plegias/Paralysis
- ☐ Seizure/Seizure disorder
- ☐ 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 _____

8f. Chronic Metabolic Disease ☐ Yes ☐ No/Unknown
- ☐ Diabetes
- ☐ Thyroid dysfunction
- ☐ 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 _____

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 _____

_____
_____
_____
_____

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	☐ 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

Treatment	Series 1 Start Date	Series 1 End Date	Series 1 Frequency and Dose	Series 2 Start Date	Series 2 End Date	Series 2 Frequency and Dose
☐ Amantadine (Symmetrel)						
☐ Rimantadine (Flumadine)						
☐ Zanamivir (Relenza)			Dose: _____ ☐ QD ☐ BID ☐ TID			Dose: _____ ☐ QD ☐ BID ☐ TID
☐ Oseltamivir (Tamiflu)			Dose: _____ ☐ QD ☐ BID ☐ TID			Dose: _____ ☐ QD ☐ BID ☐ TID
☐ Other, specify: _____			Dose: _____ ☐ QD ☐ BID ☐ TID			Dose: _____ ☐ QD ☐ BID ☐ 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:

☐ 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 ☐ 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	☐ 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: