# Influenza-Associated Pediatric Deaths Case Report Form

**Form approved**
**OMB No. 0920-0007**

**STATE USE ONLY – DO NOT SEND INFORMATION *IN THIS SECTION* TO CDC**

Last Name: _____ First Name: _____ County: _____

Address: City: State, Zip:

## Patient Demographics

| | | | |
|---|---|---|---|
| 1. State: | 2. County: | 3. State ID: | 4. CDC ID: |
| 5. Age: _____ O Days O Months O Years | 6. Date of birth: _____/ _____/ _____ MM DD YYYY | 7.Sex: O Male O Female O Unkown | 8. Ethnicity: O Hispanic or Latino O Not Hispanic or Latino O Unknown |

9. Race: ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Unknown

## Death Information

| | | |
|---|---|---|
| 10. Date of illness onset: _____/ _____/ _____ MM DD YYYY | 11. Date of death: _____/ _____/ _____ MM DD YYYY | 12. Was an autopsy performed? O Yes O No O Unknown |

13 a. Did cardiac/respiratory arrest occur outside the hospital? O Yes O No O Unknown

13 b. Location of death: O Outside the Hospital (e.g. home or in transit to hospital) O Emergency Dept (ED) O Inpatient ward O ICU O Other (specify): _____

13 c. If the death occurred in the hospital, what was the date of admission? _____/ _____/ _____ MM DD YYYY

## CDC Laboratory Specimens

14 a. Were pathology specimens sent to CDC's Infectious Diseases Pathology Branch? O Yes O No O Unknown
Please provide the lab ID No. if known_____

14 b. Were influenza isolates or original clinical material sent to CDC's Influenza Division? O Yes O No O Unknown
Please provide the lab ID No. if known_____

14 c. Were *Staph aureus* isolates sent to CDC's Division of Healthcare Quality Promotion? O Yes O No O Unknown
Please provide the lab ID No. if known_____

## Influenza Testing (check all that were used)

# Influenza-Associated Pediatric Deaths Case Report Form

| Test Type | Result | Specimen Collection Date |
|---|---|---|
| 15.<br>☐ Commercial rapid diagnostic test | O Influenza A O Influenza B O Negative<br>O Influenza A/B (Not Distinguished) O 2009 Influenza A (H1N1)<br>O Influenza virus co-infection (specify)_____ | _____/ _____/ _____ |
| ☐ Viral culture | O Influenza A (Subtyping Not Done) O Influenza B O Negative<br>O Influenza A (Unable To Subtype) O Influenza A (H1) O Influenza A (H3)<br>O 2009 Influenza A (H1N1)<br>O Influenza virus co-infection (specify)_____ | _____/ _____/ _____ |
| ☐ Fluorescent antibody (IFA or DFA) | O Influenza A (Subtyping Not Done) O Influenza B O Negative<br>O Influenza A (Unable To Subtype) O Influenza A (H1) O Influenza A (H3)<br>O 2009 Influenza A (H1N1)<br>O Influenza virus co-infection (specify)_____ | _____/ _____/ _____ |
| ☐ Enzyme immunoassay (EIA) | O Influenza A (Subtyping Not Done) O Influenza B O Negative<br>O Influenza A (Unable To Subtype) O Influenza A (H1) O Influenza A (H3)<br>O 2009 Influenza A (H1N1)<br>O Influenza virus co-infection (specify)_____ | _____/ _____/ _____ |
| ☐ RT-PCR | O Influenza A (Subtyping Not Done) O Influenza B O Negative<br>O Influenza A (Unable To Subtype) O Influenza A (H1) O Influenza A (H3)<br>O 2009 Influenza A (H1N1)<br>O Influenza virus co-infection (specify)_____ | _____/ _____/ _____ |
| ☐ Immunohistochemistry (IHC) | O Influenza A O Influenza B O Negative<br>O Influenza virus co-infection (specify)_____ | _____/ _____/ _____ |

## Culture confirmation of bacterial pathogens from STERILE (Invasive) SITES

16 a. Was a specimen collected for bacterial culture from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid O Yes O No O Unknown

16 b. If yes, please indicate the site from which the specimen was obtained and the result. *If more than one specimen type is positive and more than one organism is identified please indicate the organism cultured from each specimen type in the comments section.*

| Specimen Type | Collection Date | Result |
|---|---|---|
| ☐ Blood | Date __/__/__ | O Positive O Negative O Unknown |
| ☐ Pleural fluid | Date __/__/__ | O Positive O Negative O Unknown |
| ☐ CSF | Date __/__/__ | O Positive O Negative O Unknown |
| ☐ Other _____ | Date __/__/__ | O Positive O Negative O Unknown |
| ☐ Unknown | | |

16 c. If positive, please check the organism cultured.

☐ *Streptococcus pneumoniae*

☐ Group A streptococcus

☐ Other bacteria: _____
*(If reporting another viral co-infection please do so in section 19 Clinical Diagnosis and Complications)*

☐ *Staphylococcus aureus,* methicillin **sensitive (MSSA)**

☐ *Staphylococcus aureus,* methicillin **resistant (MRSA)**

☐ *Staphylococcus aureus,* **sensitivity not done**

☐ *Haemophilus influenzae* not-type b

☐ *Haemophilus influenzae* type b

☐ *Pseudomonas aeruginosa*

# Influenza-Associated Pediatric Deaths Case Report Form

## Culture confirmation of bacterial pathogens from NON-STERILE SITES

16 d. Were other **respiratory** specimens collected for bacterial culture (e.g., sputum, ET tube aspirate)? O Yes O No O Unknown

16 e. If yes, please indicate the site from which the specimen was obtained and the result. *If more than one specimen type is positive and more than one organism is identified please indicate the organism cultured from each specimen type in the comments section.*

| Specimen Type | Collection Date | Result |
|---|---|---|
| ☐ Sputum | Date __/__/__ | O Positive O Negative O Unknown |
| ☐ ET tube | Date __/__/__ | O Positive O Negative O Unknown |
| ☐ Other _____ | Date __/__/__ | O Positive O Negative O Unknown |
| ☐ Unknown | | |

16 f. If positive, please check the organism cultured.

| | | |
|---|---|---|
| ☐ *Streptococcus pneumoniae* | ☐ *Staphylococcus aureus*, methicillin **sensitive (MSSA)** | ☐ *Haemophilus influenzae* not-type b |
| ☐ Group A streptococcus | ☐ *Staphylococcus aureus*, methicillin **resistant (MRSA)** | ☐ *Haemophilus influenzae* type b |
| ☐ Other bacteria: _____ | ☐ *Staphylococcus aureus*, **sensitivity not done** | ☐ *Pseudomonas aeruginosa* |

*(If reporting another viral co-infection please do so in section 19 Clinical Diagnosis and Complications)*

## Pathology confirmation of bacterial pathogens

16 g. Was a specimen (e.g., fixed lung tissue) collected from an autopsy for testing of bacterial pathogens by a local or state pathologist? *(If pathology results are available from CDC it is not necessary to input those results here, however please make sure to complete section 14 "CDC Laboratory Specimens")* O Yes O No O Unknown

*If yes please indicate the results of these tests in the comments section at the end of the form.*

## Medical Care

17. Did the patient require mechanical ventilation? O Yes O No O Unknown

## Clinical Diagnoses and Complications

# Influenza-Associated Pediatric Deaths Case Report Form

18 a. Did complications occur during the acute illness? O Yes O No O Unknown

18 b. **If yes,** check all complications that occurred during the acute illness:

☐ Pneumonia (Chest X-Ray confirmed) ☐ Acute Respiratory Disease Syndrome (ARDS) ☐ Croup ☐ Seizures

☐ Bronchiolitis ☐ Encephalopathy/encephalitis ☐ Reye syndrome ☐ Shock ☐ Sepsis

☐ Another viral co-infection: _____ ☐ Other: _____

19 a. Did the child have any medical conditions that existed before the start of the acute illness? O Yes O No O Unknown

19 b. **If yes,** check all medical conditions that existed before the start of the acute illness:

☐ Moderate to severe developmental delay ☐ Hemoglobinopathy (e.g. sickle cell disease) ☐ Asthma/ reactive airway disease

☐ Diabetes mellitus ☐ History of febrile seizures ☐ Seizure disorder ☐ Cystic fibrosis

☐ Cardiac disease (specify) _____ ☐ Renal disease (specify) _____ ☐ Skin or soft tissue infection (SSTI)

☐ Chromosomal Abnormality (specify) _____ ☐ Mitochondrial Disorder (specify) _____

☐ Chronic pulmonary disease (specify) _____ ☐ Immunosuppressive condition (specify) _____

☐ Metabolic disorder (specify) _____ ☐ Neuromuscular disorder (including cerebral palsy) (specify) _____

☐ Pregnant (specify gestational age) _____ weeks ☐ Other (specify) _____

## Medication and Therapy History

20 a. Was the patient receiving any of the following therapies in the 7 days ***prior*** to illness onset ***or after*** illness onset? **(check all that apply)**

☐ Aspirin or aspirin-containing products ☐ NSAID or NSAID-containing products

20 b. Was the patient receiving any of the following therapies ***prior*** to illness onset? **(check all that apply)**

☐Antiviral Prophylaxis ☐ Chemotherapy or radiation therapy ☐ Steroids by mouth or injection ☐ other immunosuppressive therapy:_____

20 c. Was the patient receiving any of the following therapies ***after*** illness onset? **(Check all that apply)**

☐ Antibiotic therapy specify_____ ☐ Antiviral therapy specify_____

## Influenza Vaccine History

# Influenza-Associated Pediatric Deaths Case Report Form

21. Did the patient receive any **seasonal** influenza vaccine during the current season (before illness) O Yes O No O Unknown

22. **If YES*,** please specify the **seasonal** influenza vaccine received before illness onset:
- ☐ Trivalent inactivated influenza vaccine (TIV) *[injected]*
- ☐ Live-attenuated influenza vaccine (LAIV) *[nasal spray]*
- ☐ Unknown

23. **If YES for seasonal vaccine***, how many doses did the patient receive and what was the timing of each dose? (Enter vaccination dates if available)

| | | | |
|---|---|---|---|
| O 1 dose **ONLY** | ☐ <14 days prior to illness onset<br>☐ ≥14 days prior to illness onset | Date dose given:_____/ _____/ _____ MM DD YYYY | |
| O 2 doses | ☐ 2nd dose given <14 days prior to onset<br>☐ 2nd dose given ≥14 days prior to onset | Date of 1st dose: _____/ _____/_____ MM DD YYYY | Date of 2nd dose: _____/ _____/ _____ MM DD YYYY |

24 a. Did the patient receive any influenza vaccine in previous seasons? O Yes O No O Unknown

24 b. **If YES**, and patient was **≤8 years of age** at the time of death, did they receive 2 doses of vaccine during a previous season? O Yes O No O Unknown

25. Did the patient receive any **2009 Influenza A (H1N1)** vaccine during the current season (before illness) O Yes O No O Unknown

26. **If YES*,** please specify the **2009 Influenza A (H1N1)** vaccine received before illness onset:
- ☐ Trivalent inactivated influenza vaccine (TIV) *[injected]*
- ☐ Live-attenuated influenza vaccine (LAIV) *[nasal spray]*
- ☐ Unknown

27. **If YES for 2009 Influenza A (H1N1) vaccine ***, how many doses did the patient receive and what was the timing of each dose? (Enter vaccination dates if available)

| | | | |
|---|---|---|---|
| O 1 dose **ONLY** | ☐ <14 days prior to illness onset<br>☐ ≥14 days prior to illness onset | Date dose given:_____/ _____/ _____ MM DD YYYY | |
| O 2 doses | ☐ 2nd dose given <14 days prior to onset<br>☐ 2nd dose given ≥14 days prior to onset | Date of 1st dose: _____/ _____/_____ MM DD YYYY | Date of 2nd dose: _____/ _____/ _____ MM DD YYYY |

Submitted By: _____Date: _____/ _____/ _____
Phone No.: (_____) ___-_____ MM DD YYYY_____
E-mail Address: _____