Antiviral-Resistant Influenza Infection Case Report Form

Form Approved
OMB No. 0920-0004
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I. Specimen Information

State Lab Specimen ID _____
Specimen Collection State _____
Patient County of residence _____
Patient State of residence _____

Reason for Antiviral Resistance Test:
☐ Requested for Clinical Indication
☐ Surveillance
☐ Other _____

Date of Specimen Collection:
__ __/ __ __/ __ __ __ __

Specimen Type:
☐ Nasopharyngeal (NP) Swab
☐ Nasal swab
☐ Oropharyngeal Swab
☐ 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

Sex: ☐ Male ☐ Female

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race:
☐ American Indian/ Alaska Native
☐ Asian or Pacific Islander
☐ Black or African American
☐ White

Illness History:
Date of illness onset:
__ __/ __ __/ __ __ __ __
Hospitalized for illness?
☐Yes
☐No
☐Unknown

Patient Outcome:
☐ At Home
☐ At Extended Care Facility
☐ Currently Hospitalized
☐ Dead (Was it influenza-related? ☐Yes ☐ No ☐ 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:

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☐ **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: