

Emerging Infections Program
Change Request
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Background

The National Center for National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) of the Centers for Disease Control and Prevention (CDC) is requesting approval of changes to four data collection forms that have previously been approved under OMB no. 0920-0978; expiration date 8/31/2016.

These forms are used to conduct surveillance to determine the incidence and epidemiologic characteristics of invasive disease due to *Haemophilus influenzae*, *Neisseria meningitidis*, group A *Streptococcus*, group B *Streptococcus*, *Streptococcus pneumoniae*, methicillin-resistant *Staphylococcus aureus*, *Legionella spp.*, specific foodborne diseases that is captured within FoodNet and Influenza (specifically for the All Age Influenza Hospitalization Surveillance (Flu Hosp) project).

The forms for which approval for changes are being sought include:

1. 2014 ABCs Case Report Form — (Attachment 1)
2. 2014 ABCs Invasive Methicillin-resistant *Staphylococcus aureus* Case Report Form — (Attachment 2)
3. 2014 ABCs Neonatal Infection Expanded Tracking Form — (Attachment 3)
4. 2014 ABCs Legionellosis Case Report Form — (Attachment 4)
5. 2014 FoodNet Variable list — (Attachment 5)
6. 2013-14 FluSurv-NET Influenza Surveillance Project Case Report Form — (Attachment 6)
7. 2013-14 FluSurv-NET Influenza Surveillance Project Vaccination History Telephone Survey — (Attachment 7)
8. 2013-14 FluSurv-NET Influenza Surveillance Project Vaccination History Telephone Survey (Spanish) — (Attachment 8)
9. 2013-14 FluSurv-NET Influenza Surveillance Project Consent Form — (Attachment 9)
10. 2013-14 FluSurv-NET Influenza Surveillance Project Consent Form (Spanish) — (Attachment 10)

Description of Changes

Minor changes are being requested for the 2014 ABCs Case Report Form, the 2014 ABCs Invasive Methicillin-resistant *Staphylococcus aureus* Case Report Form, the 2014 Neonatal Infection Expanded Tracking Form and the 2014 ABCs Legionellosis Case Report Form in order to streamline and enhance disease surveillance for the pathogens under surveillance.

Minor changes are being requested for the 2014 FoodNet Variable list in order to improve disease surveillance under FoodNet surveillance.

Minor changes are being requested for the 2013-14 FluSurv-NET Influenza Surveillance Project Case Report Form, 2013-14 FluSurv-NET Influenza Surveillance Project Vaccination History Telephone Survey, 2013-14 FluSurv-NET Influenza Surveillance Project Vaccination History Telephone Survey (Spanish), 2013-14 FluSurv-NET Influenza Surveillance Project Consent Form, 2013-14 FluSurv-NET Influenza Surveillance Project Consent Form (Spanish) to improve surveillance of hospitalized cases affected by influenza.

The changes from the previously approved forms are minimal and the addition of forms translated to Spanish will not result in a change to previously estimated burden hours, as per communication with surveillance officers (form respondents).

Detailed Description of Changes

A. 2014 ABCs Case Report Form changes include:

1. Question 27: Underlying conditions or prior illnesses
 - Two checkboxes, 'Chronic Renal Insufficiency' and 'Renal Failure/Dialysis' have been removed.
 - Two checkboxes, 'Chronic Kidney Disease' and 'Current Chronic Dialysis' were added to distinguish between persons with underlying renal conditions that do or do not require dialysis.
2. Question 30, 'Is patient currently attending college?' has been moved to the left to be better grouped with other questions specific to cases of *N. meningitidis*.

B. 2014 ABCs Invasive Methicillin-resistant *Staphylococcus aureus* Case Report Form changes include:

1. The order of the questions have been reordered to improve logic flow and shading added to indicate core variables
2. Question 18: Supplemental Pneumonia Questions, has been removed.
3. Hospital discharge date was moved to question on patient outcome.
4. New question added, 'If yes, (to culture collected > 3 days after hospital admission) was the case selected for full CRF based on sampling frame 1:10?'
5. Modified question on BMI- added text ' (do not calculate, only if available in the MR).'
6. Underlying conditions
 - Changed 'AIDS or CD4 count < 200' to 'AIDS'
 - Changed 'Chronic Renal Insufficiency' to 'Chronic Kidney Disease'
 - Added checkbox for 'Chronic Cognitive Deficit', to more closely match the Charlson co-morbidity index.
7. Changed title of question from 'Classification – Healthcare-associated and community-associated' to 'Prior healthcare exposure – Healthcare associated and community-associated'.

C. 2014 ABCs Neonatal Infection Expanded Tracking Form changes include:

1. Question 9: new question 9c. added; 'Were **any** ICD-10 codes reported in the discharge diagnosis of the infant's chart? This was added to capture ICD-10 codes.
2. Question 9: new question 9d. added ; 'If yes, were any of the following ICD-10 codes reported in the discharge diagnosis of the chart?' This was added to capture ICD-10 codes.
3. Question 19: will no longer indent 'If delivery was by C-section...'. This will be left aligned to match the rest of the form's questions.
4. Question 26: An unknown checkbox was added for unknown dates of prenatal care visits, to indicate that the question was reviewed and data was missing.

- D. 2014 ABCs Legionellosis Case Report Form changes include:
1. Question 22: Discharge diagnosis; we are adding ICD-10 codes to the appropriate variables capturing ICD-9 codes, where matching ICD-10 codes exist.
 2. Question 23: Underlying conditions or prior illnesses
 - Two checkboxes, 'Chronic Renal Insufficiency' and 'Renal Failure/Dialysis' have been removed.
 - Two checkboxes, 'Chronic Kidney Disease' and 'Current Chronic Dialysis' were added to distinguish between persons with underlying renal conditions that do or do not require dialysis.
- E. 2014 FoodNet Variable list changes include:
1. Variable 2: Expanded the list of responses for 'AgClinicTestType' to reflect new tests that are now being used in clinical labs.
 2. Variables 80 & 81: Added two new variables ('DXO157' and 'DXO157TestType') related to culture-independent testing for STEC.
 3. Variables 10-57: Added new variables to capture case exposure information to be used for attribution estimates. These variables were developed by a working group consisting of CDC and state health department sites over a two-year period. Variables were pilot-tested in 4 sites for a three-month period for Salmonella and Campylobacter cases. These variables are already being captured by state health departments on their state forms.
- F. 2013-14 FluSurv-NET Influenza Surveillance Project Case Report Form
1. To better characterize the types of FluSurv-NET cases, a question has been added to differentiate between patients admitted to the hospital versus those who are kept under observation for 24 hours or more.
 2. To better classify patient's residence before hospitalization, we have replaced the long term care facility information open text fields and replaced them with checkboxes of the most common responses for residence prior to hospitalization.
 3. Question regarding whether or not patient worked in the healthcare industry has been removed.
 4. To better capture information regarding symptoms at the time of admission, question E2 "Reason for current admission" has been rephrased to "Acute conditions at admission".
 5. To better understand high risk behaviors associated with influenza hospitalizations, questions regarding previous and current smoking status and previous and current alcohol abuse have been added
 6. A question has been added for the patient's total number of ICU admissions during current hospitalization to better capture the history of the

hospitalization since a patient may have more than one admission to state forsmthe ICU.

7. The antiviral treatment section of the case report form has been reformatted to better capture treatment information, including method of administration and multiple series of medications

8. The options for terms abstracted from radiographic reports were modified slightly to harmonize with other surveillance tools already in use in similar catchment areas.

9. The options available for discharge locations have been modified to make the form consistent with the information encountered by the surveillance officers when abstracting data from medical charts.

10. Vaccination history for mothers of patients < 6 months of age will no longer be collected.

11. The section on vaccination status was simplified. We will capture vaccination status according to each data source used at the surveillance area and vaccine type will no longer be collected.

12. Pneumococcal vaccination status will no longer be collected.

G. 2013-14 FluSurv-NET Influenza Surveillance Project Vaccination History Telephone Survey

1. To reflect changes made in the 2013-14 FluSurv-NET Influenza Surveillance Project Case Report Form, the 2013-14 FluSurv-NET Influenza Surveillance Project Vaccination History Telephone Survey was simplified.
 - Vaccination history for mothers of patients < 6 months of age will no longer be collected.
 - The vaccine type will no longer be collected.
 - Pneumococcal vaccination status will no longer be collected.

H. 2013-14 FluSurv-NET Influenza Surveillance Project Vaccination History Telephone Survey (Spanish)

1. To better obtain surveillance information of Spanish-speaking individuals, the 2013-14 FluSurv-NET Influenza Surveillance Project Vaccination History Telephone Survey has been translated into Spanish.

I. 2013-14 FluSurv-NET Influenza Surveillance Project Consent Form

1. Instructions on where to proceed after the interviewee consents to the continuation of the interview has been changed to better reflect this season's instructions.

J. 2013-14 FluSurv-NET Influenza Surveillance Project Consent Form (Spanish)

1. To better obtain surveillance information of Spanish-speaking individuals, the 2013-14 FluSurv-NET Influenza Surveillance Project Consent Form has been translated into Spanish.

Cross walk of 2014 form changes

A. 2014 ABCs Case Report Form

<u>Question on 2013 form</u>	<u>Question on 2014 form</u>
27. Underlying conditions 1 <input type="checkbox"/> Chronic Renal Insufficiency 1 <input type="checkbox"/> Renal Failure/Dialysis	27. Underlying conditions 1 <input type="checkbox"/> Chronic Kidney Disease 1 <input type="checkbox"/> Current Chronic Dialysis

B. 2014 ABCs Invasive Methicillin-resistant *Staphylococcus aureus* Case Report Form

<u>Question on 2013 form</u>	<u>Question on 2014 form</u>
18. Supplemental Pneumonia Questions. Please complete if the patient was determined to have pneumonia per question 15a (Timeframe of interest: within +/- 3 calendar days of initial culture)	Removed
9. Was the patient hospitalized, at the time of, or in the 30 calendar days, after initial culture? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If yes, date of admission: MM/DD/YYYY Date of discharge: MM/DD/YYYY	18. Patient Outcome 9 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Survived Date of discharge: MM/DD/YYYY 2 <input type="checkbox"/> Died Date of death: MM/DD/YYYY
17. Classification – Healthcare-associated and community-associated: (Check all that apply) 1 <input type="checkbox"/> Culture collected >3 calendar days after hospital admission.	11. Was culture collected >3 calendar days after hospital admission? 1 <input type="checkbox"/> Yes (HO-MRSA case) 2 <input type="checkbox"/> No (Complete CRF, CA-MRSA or HACO-MRSA case) If yes, was the case selected for full CRF based on sampling frame 1:10? 1 <input type="checkbox"/> Yes (Complete CRF) 2 <input type="checkbox"/> No (STOP data abstraction)
8f. BMI: _____ <input type="checkbox"/> unknown	12e. BMI: _____ (do not calculate, only if available in MR) <input type="checkbox"/> unknown
16. Underlying conditions 1 <input type="checkbox"/> AIDS or CD4 count <200 1 <input type="checkbox"/> Chronic Renal Insufficiency	20. Underlying conditions 1 <input type="checkbox"/> AIDS 1 <input type="checkbox"/> Chronic Renal Disease 1 <input type="checkbox"/> Chronic Cognitive Deficit
17. Classification – Healthcare-associated and community-associated: (Check all that apply)	21. Prior Healthcare Exposure - Healthcare-associated and community-associated: (Check all that apply)

C. 2014 ABCs Neonatal Infection Expanded Tracking Form

Question on 2013 form	Question on 2014 form
N/A	9c. Were <i>any</i> ICD-10 codes reported in the discharge diagnosis of the infant's chart?
N/A	9d. IF YES, were any of the following ICD-10 codes reported in the discharge diagnosis of the chart? (<i>Check all that apply</i>) 1 <input type="checkbox"/> B36: Bacterial sepsis of newborn 1 <input type="checkbox"/> B36.0: Sepsis of newborn due to streptococcus, group B 1 <input type="checkbox"/> B36.1: Sepsis of newborn to other and unspecified streptococci 1 <input type="checkbox"/> B95.1: Streptococcus, group b as the cause of diseases classified elsewhere 1 <input type="checkbox"/> A40.1: Sepsis due to streptococcus, group B 1 <input type="checkbox"/> A40.9: Streptococcus sepsis, unspecified 1 <input type="checkbox"/> B95.5: Unspecified streptococcus as the cause of diseases classified elsewhere 1 <input type="checkbox"/> G00.2: Streptococcal meningitis
26. Please record the following: the total number of prenatal visits AND the first and last visit dates to the prenatal provider as recorded in the labor and delivery chart. No. of visits: ____ First visit: MM/DD/YYYY Last visit: MM/DD/YYYY	26. Please record the following: the total number of prenatal visits AND the first and last visit dates to the prenatal provider as recorded in the labor and delivery chart. No. of visits: ____ First visit: MM/DD/YYYY Last visit: MM/DD/YYYY 1 <input type="checkbox"/> Unknown

D. 2014 ABCs Legionellosis Case Report Form

Question on 2013 form	Question on 2014 form
22. Discharge diagnosis 1 <input type="checkbox"/> 482.84 (Legionnaire's disease) 1 <input type="checkbox"/> 482 (Other bacterial pneumonia) 1 <input type="checkbox"/> 482.3 (Pneumonia due to other specified bacteria)	22. Discharge diagnosis 1 <input type="checkbox"/> 482.84/A48.1 (Legionnaire's disease) 1 <input type="checkbox"/> 482 (Other bacterial pneumonia) 1 <input type="checkbox"/> 482.3 (Pneumonia due to other

<input type="checkbox"/> 482.83 (Other gram-negative bacteria) <input type="checkbox"/> 482.89 (Pneumonia due to other specified bacteria) <input type="checkbox"/> 482.9 (Bacterial pneumonia unspecified) <input type="checkbox"/> 483 (Pneumonia due to other specified organism) <input type="checkbox"/> 483.8 (Pneumonia due to other specified organism) <input type="checkbox"/> 484 (Pneumonia in infectious diseases classified elsewhere) <input type="checkbox"/> 484.8 (Pneumonia in infectious diseases classified elsewhere) <input type="checkbox"/> 485 (Bronchopneumonia, organism unspecified) <input type="checkbox"/> 486 (Pneumonia, organism unspecified) <input type="checkbox"/> None of these listed <input type="checkbox"/> No ICD-9 codes in chart	specified bacteria) <input type="checkbox"/> 482.83/J15.6 (Other gram-negative bacteria) <input type="checkbox"/> 482.89/J15.8 (Pneumonia due to other specified bacteria) <input type="checkbox"/> 482.9/J15.9 (Bacterial pneumonia unspecified) <input type="checkbox"/> 483 (Pneumonia due to other specified organism) <input type="checkbox"/> 483.8/J16.8 (Pneumonia due to other specified organism) <input type="checkbox"/> 484 (Pneumonia in infectious diseases classified elsewhere) <input type="checkbox"/> 484.8/J17 (Pneumonia in infectious diseases classified elsewhere) <input type="checkbox"/> 485/J18.0 (Bronchopneumonia, organism unspecified) <input type="checkbox"/> 486/J18.9 (Pneumonia, organism unspecified) <input type="checkbox"/> None of these listed <input type="checkbox"/> No ICD codes in chart
23. Underlying conditions <input type="checkbox"/> Chronic Renal Insufficiency <input type="checkbox"/> Renal Failure/Dialysis	23. Underlying conditions <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Current Chronic Dialysis

E. 2014 FoodNet Variable list

Variable list 2012	Variable list 2014
2. AgClinicTestType <input type="checkbox"/> Immunocard STAT! EHEC (Meridian); <input type="checkbox"/> Duopath Verotoxins (Merck); <input type="checkbox"/> Premier EHEC (Meridian); <input type="checkbox"/> ProSpecT STEC (Remel); <input type="checkbox"/> VTEC Screen (Denka Seiken); <input type="checkbox"/> ImmunoCard STAT! Crypto/Giardia (Meridian); <input type="checkbox"/> XPect Cryptosporidium (Remel); <input type="checkbox"/> XPect Crypto/Giardia (Remel); <input type="checkbox"/> ColorPAC Crypto/Giardia (Becton Dickinson); <input type="checkbox"/> ProSpecT Cryptosporidium (Remel); <input type="checkbox"/> ProSpecT Crypto/Giardia (Remel); <input type="checkbox"/> Wampole EIA Cryptosporidium; <input type="checkbox"/> TechLab EIA Cryptosporidium;	2. AgClinicTestType <input type="checkbox"/> Alere Shiga Toxin Quik Chek <input type="checkbox"/> Immunocard STAT! EHEC (Meridian); <input type="checkbox"/> Duopath Verotoxins (Merck); <input type="checkbox"/> Premier EHEC (Meridian); <input type="checkbox"/> ProSpecT STEC (Remel); <input type="checkbox"/> VTEC Screen (Denka Seiken); <input type="checkbox"/> Alere Giardia/Crypto Quik Chek <input type="checkbox"/> ImmunoCard STAT! Crypto/Giardia (Meridian); <input type="checkbox"/> XPect Cryptosporidium (Remel); <input type="checkbox"/> XPect Crypto/Giardia (Remel); <input type="checkbox"/> ColorPAC Crypto/Giardia (Becton Dickinson); <input type="checkbox"/> ProSpecT Cryptosporidium (Remel); <input type="checkbox"/> ProSpecT Crypto/Giardia (Remel);

<p>1 <input type="checkbox"/> Crypto CELISA (Cellabs); 1 <input type="checkbox"/> Para-TECT Crypto Antigen 96 (Medical Chemical Corporation); 1 <input type="checkbox"/> Triage parasite panel (BioSite) ProSpecT Campylobacter assay (Remel); 1 <input type="checkbox"/> PREMIER™ CAMPY assay (Meridian); 1 <input type="checkbox"/> ImmunoCard STAT! CAMPY (Meridian); 1 <input type="checkbox"/> Xpect Campylobacter assay (Remel); 1 <input type="checkbox"/> Other; 1 <input type="checkbox"/> Unknown</p>	<p>1 <input type="checkbox"/> Wampole EIA Cryptosporidium; 1 <input type="checkbox"/> TechLab EIA Cryptosporidium; 1 <input type="checkbox"/> Crypto CELISA (Cellabs); 1 <input type="checkbox"/> Para-TECT Crypto Antigen 96 (Medical Chemical Corporation); 1 <input type="checkbox"/> Triage parasite panel (BioSite) ProSpecT Campylobacter assay (Remel); 1 <input type="checkbox"/> PREMIER™ CAMPY assay (Meridian); 1 <input type="checkbox"/> ImmunoCard STAT! CAMPY (Meridian); 1 <input type="checkbox"/> Xpect Campylobacter assay (Remel); 1 <input type="checkbox"/> Other; 1 <input type="checkbox"/> Unknown</p>
<p>N/A</p>	<p>10. CEA_Beef 11. CEA_Beef_grnd 12. CEA_Beef_out 13. CEA_Beef_unckgrnd 14. CEA_Berries 15. CEA_Bird 16. CEA_Cantaloupe 17. CEA_Cat 18. CEA_Chicken 19. CEA_Chx_grnd 20. CEA_Chx_out 21. CEA_Dairy 22. CEA_Dog 23. CEA_Eggs 24. CEA_Eggs_out 25. CEA_Eggs_unck 26. CEA_Farm_ranch 27. CEA_Fish 28. CEA_Fish_unck 29. CEA_Herbs 30. CEA_Lettuce 31. CEA_Live_poultry 32. CEA_Milk_raw 33. CEA_Odairy_raw 34. CEA_Ountreat_water 35. CEA_Pig 36. CEA_Pocketpet 37. CEA_Pork 38. CEA_Raw_cider 39. CEA_Reptile_amphib 40. CEA_Ruminants 41. CEA_Seafd 42. CEA_Seafd_unck 43. CEA_Sewer_water</p>

	44. CEA_Sick_contact 45. CEA_Sick_pet 46. CEA_Softcheese 47. CEA_Softcheese_raw 48. CEA_Spinach 49. CEA_Sprouts 50. CEA_Swim_treat 51. CEA_Swim_untreat 52. CEA_Tomatoes 53. CEA_Turkey 54. CEA_Turkey_grnd 55. CEA_Turkey_out 56. CEA_Watermelon 57. CEA_Well_water Responses for all variables listed above (<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown)
N/A	80. DXO157 1 <input type="checkbox"/> Positive; 1 <input type="checkbox"/> Negative; 1 <input type="checkbox"/> Not tested
N/A	81. DXO157TestType 1 <input type="checkbox"/> ImmunoCard STAT! O157 (Meridian) 1 <input type="checkbox"/> Diatherix; 1 <input type="checkbox"/> Luminex; 1 <input type="checkbox"/> Metamatrix; 1 <input type="checkbox"/> Other

F. 2013-14 FluSurv-NET Influenza Surveillance Project Case Report Form

<u>Question on 2011-12 Form</u>	<u>Question on 2013-14 Form</u>
N/A	C2. Admission Type: <input type="checkbox"/> Hospitalization <input type="checkbox"/> Observation Only
C12. 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	C13. Where did patient reside at the time of hospitalization? Indicate TYPE of residence. <input type="checkbox"/> Private residence <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Group home/Retirement home <input type="checkbox"/> Assisted living/Residential care <input type="checkbox"/> Homeless/Shelter <input type="checkbox"/> Nursing home <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____
C12a. If yes, indicate TYPE of facility: _____	Removed
C13. Does patient work in the healthcare industry? <input type="checkbox"/> Yes	Removed

<input type="checkbox"/> No <input type="checkbox"/> Unknown	
E2. Reason for current admission (Check all that apply): <input type="checkbox"/> Acute respiratory illness <input type="checkbox"/> Asthma and/or COPD exacerbation <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other respiratory or cardiac conditions <input type="checkbox"/> Other, neither respiratory nor cardiac conditions <input type="checkbox"/> Unknown	E2. Acute conditions at admission (Check all that apply): <input type="checkbox"/> Acute respiratory illness <input type="checkbox"/> Asthma and/or COPD exacerbation <input type="checkbox"/> Fever <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other respiratory or cardiac conditions <input type="checkbox"/> Other, neither respiratory nor cardiac conditions <input type="checkbox"/> Unknown
N/A	E7. Smoker: <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> No/Unknown
N/A	E8. Alcohol abuse: <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> No/Unknown
N/A	F1a. Number of ICU Admissions _____ <input type="checkbox"/> Unknown
I1a. If yes, indicate which antiviral medication(s) were used, or check unknown: <input type="checkbox"/> Antiviral Medication(s) Unknown	Removed

Question on 2011-12 Form	Question on 2013-14 Form
I1a. If yes, indicate which antiviral medication(s) were used, or check unknown: <input type="checkbox"/> Amantadine (Symmetrel) Series 1: <u>[Start Date]</u> <u>[End Date]</u> Series 2: <u>[Start Date]</u> <u>[End Date]</u> <input type="checkbox"/> Rimantadine (Flumadine) Series 1: <u>[Start Date]</u> <u>[End Date]</u> Series 2: <u>[Start Date]</u> <u>[End Date]</u> <input type="checkbox"/> Zanamivir (Relenza) Series 1: <u>[Start Date]</u> <u>[End Date]</u> <u>[Frequency and Dose]</u> Series 2: <u>[Start Date]</u> <u>[End Date]</u> <u>[Frequency and Dose]</u> <input type="checkbox"/> Oseltamivir (Tamiflu) Series 1: <u>[Start Date]</u> <u>[End Date]</u> <u>[Frequency and Dose]</u> Series 2: <u>[Start Date]</u> <u>[End Date]</u> <u>[Frequency and Dose]</u> <input type="checkbox"/> Other, specify: _____ Series 1: <u>[Start Date]</u> <u>[End Date]</u> <u>[Frequency and Dose]</u> Series 2: <u>[Start Date]</u> <u>[End Date]</u> <u>[Frequency and Dose]</u>	I2a-I5a. Treatment 1-4: <input type="checkbox"/> Oseltamivir (Tamiflu) <input type="checkbox"/> Zanamivir (Relenza) <input type="checkbox"/> Amantadine (Symmetrel) <input type="checkbox"/> Rimantadine (Flumadine) <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown

N/A	I2b-I5b. Method of Administration: <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous (IV) <input type="checkbox"/> Inhaled <input type="checkbox"/> Unknown
N/A	I2c-I5c. Start Date: ___/___/___ <input type="checkbox"/> Start Date Unknown
N/A	I2d-I5d. End Date: ___/___/___ <input type="checkbox"/> End Date Unknown
N/A	I2e-I5e. Dose _____ <input type="checkbox"/> Dose Unknown
N/A	I2f-I5f. Frequency: _____ <input type="checkbox"/> Frequency Unknown
J2b. 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: _____	J2b. For first abnormal chest x-ray, please check all that apply: <input type="checkbox"/> Report not available <input type="checkbox"/> Consolidation <input type="checkbox"/> Interstitial infiltrate <input type="checkbox"/> Air space density/opacity <input type="checkbox"/> Atelectasis <input type="checkbox"/> Pleural effusion/empyema <input type="checkbox"/> Bronchopneumonia/pneumonia <input type="checkbox"/> Cavitation <input type="checkbox"/> Lobar (NOT interstitial) infiltrate <input type="checkbox"/> Cannot rule out pneumonia <input type="checkbox"/> ARDS (acute respiratory distress syndrome) <input type="checkbox"/> Other

Question on 2011-12 Form	Question on 2013-14 Form
N/A	J2c. Please specify location for bronchopneumonia/pneumonia/consolidation/lobar infiltrate/air space density/opacity: <input type="checkbox"/> Single lobar <input type="checkbox"/> Multiple lobar (unilateral) <input type="checkbox"/> Multiple lobar (bilateral) <input type="checkbox"/> Unknown
K3a. If discharged alive, please indicate to where: <input type="checkbox"/> Home <input type="checkbox"/> Other hospital <input type="checkbox"/> Hospice <input type="checkbox"/> Long-term care facility <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown	K2a. If discharged alive, please indicate to where: <input type="checkbox"/> Home <input type="checkbox"/> Other hospital <input type="checkbox"/> Hospice/Home hospice <input type="checkbox"/> Homeless/Shelter <input type="checkbox"/> Rehabilitation Facility <input type="checkbox"/> Group home/Retirement home <input type="checkbox"/> Assisted living/Residential Care <input type="checkbox"/> Home with Services <input type="checkbox"/> Nursing home <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown
M1. Did patient's <u>mother</u> receive the influenza vaccine during fall or winter of the current influenza season? <input type="checkbox"/> Yes <input type="checkbox"/> No	Removed

<input type="checkbox"/> Unknown	
M1a. If yes, specify <u>mother's</u> vaccine type: <input type="checkbox"/> Injected Vaccine – Trivalent inactivated influenza vaccine (TIV) <input type="checkbox"/> Nasal Spray – Live attenuated influenza vaccine (LAIV) <input type="checkbox"/> Vaccine type unknown	Removed
M2b. If yes, specify <u>patient's</u> vaccine type: <input type="checkbox"/> Injected Vaccine – Trivalent inactivated influenza vaccine (TIV) <input type="checkbox"/> Nasal Spray – Live attenuated influenza vaccine (LAIV) <input type="checkbox"/> Vaccine type unknown	Removed
M2c. If patient ≥ 18 years and received injected vaccine (TIV), please specify type: <input type="checkbox"/> Regular IM <input type="checkbox"/> High dose IM <input type="checkbox"/> Intradermal <input type="checkbox"/> TIV type unknown	Removed
M4. Did patient receive any type of pneumococcal vaccine at any age? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Removed

<u>Question on 2011-12 Form</u>	<u>Question on 2013-14 Form</u>
M4a. If yes, please provide dosage date information: Dose 1 ___/___/___ Dose 2 ___/___/___ Dose 3 (Pediatrics Only) ___/___/___ Dose 4 (Pediatrics Only) ___/___/___	Removed
M4b. If patient ≥ 65 years, was vaccine received within last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Removed

G. 2013-14 FluSurv-NET Influenza Surveillance Project Vaccination History Telephone Survey

<u>Question on 2011-12 Form</u>	<u>Question on 2013-14 Form</u>
Patients <6 months old: 1) Did [you (if speaking to patient's mother)/patient's mother] receive the influenza vaccine during fall or winter of the current influenza season? <input type="checkbox"/> Yes (go to Q1a)	Removed

<input type="checkbox"/> No (go to Q2) <input type="checkbox"/> Unknown (go to Q2)	
Patients <6 months old: 1a) If yes, what vaccine type did [you/the patient's mother] receive? <input type="checkbox"/> Shot [Injected vaccine --Trivalent inactivated influenza vaccine (TIV)] <input type="checkbox"/> Spray [Nasal spray -- Live-attenuated influenza vaccine (LAIV)] <input type="checkbox"/> Unknown	Removed
Patients <6 months old: 1b) What type of injected vaccine did [you/patient's mother] receive? <input type="checkbox"/> Regular IM <input type="checkbox"/> High dose IM <input type="checkbox"/> Intradermal <input type="checkbox"/> TIV type unknown	Removed
Patients <6 months old: 2) At any time, did [your child/patient's name] receive the pneumonia vaccine [may need to read: pneumococcal, PCV(7), PCV(13), or Prevnar®]? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Removed
Patients <6 months old: 2a) Can you tell me the dates [your child's/patient's name] received the pneumonia vaccine? 1) _____ - _____ - _____ [MM-DD-YYYY] 2) _____ - _____ - _____ [MM-DD-YYYY] 3) _____ - _____ - _____ [MM-DD-YYYY] 4) _____ - _____ - _____ [MM-DD-YYYY]	Removed
Patients <6 months old: 3) Can you tell me what is [your child's/patient's name] race (check all that apply)?	Removed

<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Multiracial, unspecified <input type="checkbox"/> Not specified (refused) Are you / they....? <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino	
Children >6 months old and Adults: 1b) Did [you/child's name] receive a shot or was it sprayed into their nose? <input type="checkbox"/> Shot [Injected vaccine --Trivalent inactivated influenza vaccine (TIV)] <input type="checkbox"/> Spray [Nasal spray -- Live-attenuated influenza vaccine (LAIV)] <input type="checkbox"/> Unknown	Removed
Children >6 months old: 3). At any time, did [you/child's name] receive the pneumonia vaccine [may need to read: pneumococcal, PCV(7), PCV(13), or Prevnar®]? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Removed
Adult Patient: 1b) Did [you/child's name] receive a shot or was it sprayed into their nose? <input type="checkbox"/> Shot [Injected vaccine --Trivalent inactivated influenza vaccine (TIV)] <input type="checkbox"/> Spray [Nasal spray -- Live-attenuated influenza vaccine (LAIV)] <input type="checkbox"/> Unknown	Removed
Adult Patient: 1c) What type of injected vaccine did [you/patient's name] receive? <input type="checkbox"/> Regular IM <input type="checkbox"/> High dose IM <input type="checkbox"/> Intradermal <input type="checkbox"/> TIV type unknown	Removed

<p>Adult Patients:</p> <p>2) At any time, did [you/patient's name] receive the pneumonia vaccine [may need to read: pneumococcal, Pneumovax®]?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>	<p>Removed</p>
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- H. 2013-14 FluSurv-NET Influenza Surveillance Project Vaccination History Telephone Survey (Spanish)
- a. To better obtain surveillance information of Spanish-speaking individuals, the 2013-14 FluSurv-NET Influenza Surveillance Project Vaccination History Telephone Survey has been translated into Spanish.

I. 2013-14 FluSurv-NET Influenza Surveillance Project Consent Form

Question on 2011-12 Form	Question on 2013-14 Form
<p>Hello. My name is _____ from the ____ [state] Department of Public Health. May I speak to _____ [patient's name /parent of [child's name]] . We are working with the Centers for Disease Control and Prevention and other health departments to learn more about influenza disease or the flu. To do this, we are talking to people who have been in the hospital with the flu. We want to look at things that may affect their illness and whether they were vaccinated against the flu.</p> <p>Because you/your child [or NAME if speaking with proxy] were in the hospital for the flu beginning on _____ [day admitted], I would like to ask you a few questions about whether you/your child [or NAME if speaking with proxy] received the flu vaccine this season. This will take about five minutes. Your participation is voluntary and if you choose to refuse it will not affect any medical care or benefits you receive. All of your responses will be kept confidential as much as the law allows. You may refuse to answer any questions and may stop at any time. This information will help [State/Local Health Department] and CDC better describe influenza-associated hospitalizations. Additionally, this information may help us improve vaccination recommendations for flu and better protect the public's health. There is no other benefit to you for answering these questions. There is also no risk to you. If you have any questions about the study, you may call _____ [state contact] at the Department of Public Health at XXX-XXX-XXXX. Do you have any questions before I begin?</p>	<p>Hello. My name is _____ from the ____ [state] Department of Public Health. May I speak to _____ [patient's name /parent of [child's name]] . We are working with the Centers for Disease Control and Prevention and other health departments to learn more about influenza disease or the flu. To do this, we are talking to people who have been in the hospital with the flu. We want to look at things that may affect their illness and whether they were vaccinated against the flu.</p> <p>Because you/your child [or NAME if speaking with proxy] were in the hospital for the flu beginning on _____ [day admitted], I would like to ask you a few questions about whether you/your child [or NAME if speaking with proxy] received the flu vaccine this season. This will take about five minutes. Your participation is voluntary and if you choose to refuse it will not affect any medical care or benefits you receive. All of your responses will be kept confidential as much as the law allows. You may refuse to answer any questions and may stop at any time. This information will help [State/Local Health Department] and CDC better describe influenza-associated hospitalizations. Additionally, this information may help us improve vaccination recommendations for flu and better protect the public's health. There is no other benefit to you for answering these questions. There is also no risk to you. If you have any questions about the study, you may call _____ [state contact] at the Department of Public Health at XXX-XXX-XXXX. Do you have any questions before I begin?</p>

<p>May I continue with this interview? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, go to Appendix D. If NO: Thank you for your time. Have a good day.</p>	<p>May I continue with this interview? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, go to Appendix F. If NO: Thank you for your time. Have a good day.</p>
<p>Question on 2011-12 Form</p>	<p>Question on 2013-14 Form</p>
<p>Hello. My name is _____ from the ____ [state] Department of Public Health. May I speak to _____ [patient's name /parent of [child's name]] . We are working with the Centers for Disease Control and Prevention and other health departments to learn more about influenza disease or the flu. To do this, we are talking to people who have been in the hospital with the flu. We want to look at things that may affect their illness and whether they were vaccinated against the flu.</p> <p>Because you/your child [or NAME if speaking with proxy] were in the hospital for the flu beginning on _____ [day admitted], I would like to ask you a few questions about whether you/your child [or NAME if speaking with proxy] received the flu vaccine this season. This will take about five minutes. Your participation is voluntary and if you choose to refuse it will not affect any medical care or benefits you receive. All of your responses will be kept confidential as much as the law allows. You may refuse to answer any questions and may stop at any time. This information will help [State/Local Health Department] and CDC better describe influenza-associated hospitalizations. Additionally, this information may help us improve vaccination recommendations for flu and better protect the public's health. There is no other benefit to you for answering these questions. There is also no risk to you. If you have any questions about the study, you may call _____ [state contact] at the Department of Public Health at XXX-XXX-XXXX. Do you have any questions before I begin?</p> <p>May I continue with this interview? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, go to Appendix D. If NO: Thank you for your time. Have a good day.</p>	<p>Hello. My name is _____ from the ____ [state] Department of Public Health. May I speak to _____ [patient's name /parent of [child's name]] . We are working with the Centers for Disease Control and Prevention and other health departments to learn more about influenza disease or the flu. To do this, we are talking to people who have been in the hospital with the flu. We want to look at things that may affect their illness and whether they were vaccinated against the flu.</p> <p>Because you/your child [or NAME if speaking with proxy] were in the hospital for the flu beginning on _____ [day admitted], I would like to ask you a few questions about whether you/your child [or NAME if speaking with proxy] received the flu vaccine this season. This will take about five minutes. Your participation is voluntary and if you choose to refuse it will not affect any medical care or benefits you receive. All of your responses will be kept confidential as much as the law allows. You may refuse to answer any questions and may stop at any time. This information will help [State/Local Health Department] and CDC better describe influenza-associated hospitalizations. Additionally, this information may help us improve vaccination recommendations for flu and better protect the public's health. There is no other benefit to you for answering these questions. There is also no risk to you. If you have any questions about the study, you may call _____ [state contact] at the Department of Public Health at XXX-XXX-XXXX. Do you have any questions before I begin?</p> <p>May I continue with this interview? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, go to Appendix F. If NO: Thank you for your time. Have a good day.</p>

J. 2013-14 FluSurv-NET Influenza Surveillance Project Consent Form (Spanish)

- a. To better obtain surveillance information of Spanish-speaking individuals, the 2013-14 FluSurv-NET Influenza Surveillance Project Consent Form has been translated into Spanish.