

## Antiviral-Resistant Influenza Infection Case Report Form

Form Approved  
OMB No. 0920-0004

**FAX COMPLETED FORM TO: 404-639-3866**

**CDC ID (CDC use only):** \_\_\_\_\_

I. Specimen Information			
State Lab Specimen ID _____ Specimen Collection State _____ Patient County of residence _____ Patient State of residence _____ Oseltamivir resistance <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<b>Reason for Antiviral Resistance Test:</b> <input type="checkbox"/> Requested for Clinical Indication <input type="checkbox"/> Surveillance <input type="checkbox"/> Other _____	<b>Specimen Type:</b> <input type="checkbox"/> Nasopharyngeal (NP) Swab <input type="checkbox"/> Nasal swab <input type="checkbox"/> Oropharyngeal Swab <input type="checkbox"/> Bronchoalveolar Lavage <input type="checkbox"/> Other _____	
<b>II. Basic Information</b> If information is from patient interview please READ: <i>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.</i>			
<b>Age:</b> ____ <input type="checkbox"/> yrs <input type="checkbox"/> months <b>Is sex known?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <b>Is ethnicity known?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<b>Is race known?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Race:</b> <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other _____	<b>Illness History:</b> Date of illness onset: ____/____/_____ Hospitalized for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Patient Outcome:</b> <input type="checkbox"/> At Home <input type="checkbox"/> At Extended Care Facility <input type="checkbox"/> Currently Hospitalized <input type="checkbox"/> Dead (Was it influenza-related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown) <input type="checkbox"/> Unknown
III. Pre-existing Medical Conditions			
<b>Did a doctor ever tell you that you (your child) had any of the following conditions? (Check all that apply)</b>			
<input type="checkbox"/> No underlying conditions <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Chronic kidney disease <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic lung disease (non-asthma), specify _____ <input type="checkbox"/> Neurologic/neuromuscular disease			
<input type="checkbox"/> Immunosuppressive condition ( <b>complete section X</b> ) <input type="checkbox"/> Chronic Heart Disease, specify: _____ <input type="checkbox"/> Chronic Liver Disease, specify: _____ <input type="checkbox"/> Morbid obesity: Height _____ Weight _____ <input type="checkbox"/> Other Condition, specify: _____ If female aged ≥16 years, were you pregnant at time of specimen collection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Trimester _____			
IV. Hospitalized Patient Information (skip to section V if patients is not hospitalized)			
Date of hospital admission: ____/____/_____		Date of hospital discharge: ____/____/_____	
Where was the patient discharged to? <input type="checkbox"/> Other hospital <input type="checkbox"/> Home <input type="checkbox"/> Hospice <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Long term care facility <input type="checkbox"/> Other			
Reason for Hospital Admission: <input type="checkbox"/> Respiratory Illness <input type="checkbox"/> Other, specify: _____			
During hospitalization, was patient:			
In Intensive Care Unit? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Mechanically Ventilated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	On Vasopressors? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Renal Failure requiring Dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
V. Influenza Antiviral Medication History			
Received influenza antiviral medications including oseltamivir (Tamiflu®) or zanamivir (Relenza®)? <input type="checkbox"/> Yes <input type="checkbox"/> No ( <b>skip to section VI</b> ) <input type="checkbox"/> Unknown ( <b>skip to section VI</b> )			
<b>If yes, Please check all below that apply:</b>			

Public reporting burden of this collection of information is estimated to average 30 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 (0920-0004).

<input type="checkbox"/> <b>Oseltamivir (Tamiflu)</b> Dose: <input type="checkbox"/> 75mg <input type="checkbox"/> Other _____ Frequency: <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> Other _____ Indication: <input type="checkbox"/> Treatment <input type="checkbox"/> Prevention Location: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient Start Date: ___/___/_____ End Date:   ___/___/_____ 	<input type="checkbox"/> <b>Zanamivir (Relenza)</b> Dose: <input type="checkbox"/> 10mg <input type="checkbox"/> Other _____ Route: <input type="checkbox"/> Inhaled <input type="checkbox"/> IV (experimental) Frequency: <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> Other _____ Indication: <input type="checkbox"/> Treatment <input type="checkbox"/> Prevention Location: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient Start Date: ___/___/_____ End Date:   ___/___/_____ 	<input type="checkbox"/> <b>Additional/other Agent</b> Name: _____ Dose: _____ Route: <input type="checkbox"/> Oral <input type="checkbox"/> IV <input type="checkbox"/> Inhaled Frequency: <input type="checkbox"/> BID <input type="checkbox"/> Other _____ Indication: <input type="checkbox"/> Treatment <input type="checkbox"/> Prevention Location: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient Start Date: ___/___/_____ End Date:   ___/___/_____ 
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Patient finished all of the pills (or suspension)?  Yes    No    Unknown

Information on antiviral treatment is from (check all that apply)  
 inpatient medical record    outpatient medical record    dispensing pharmacy    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. Clinical Illness** [Read to patient: *I am going to ask you some questions about your (your child's) illness. Please feel free to look at the calendar to help you remember.*]

1. Did you (your child) have a fever or feel feverish when you (he/she) had flu?    Yes    No (skip to Q2)    DK (skip to Q2)  
1a. How many days did you (your child) have fever?     \_\_\_\_\_ day(s)  
1b. Did you take your (your child's) temperature?      Yes    No (skip to Q2)    DK (skip to Q2)  
1c. What was the highest temperature that you recorded?   \_\_\_\_\_

2. Did you (your child) have a new cough with your flu illness?            Yes    No    DK  
3. Did you (your child) have achy muscles or joints with your flu illness?    Yes    No    DK  
4. Did you have diarrhea (loose stools three times a day) with your flu illness?  Yes    No    DK  
5. Did you have vomiting with your flu illness?                                Yes    No    DK  
6. On what date did you first seek medical care for the flu illness?   \_\_\_/\_\_\_/\_\_\_\_\_  
7. Did you need to return for additional care after that visit?    Yes    No    N/A  
8. How many days did your (your child's) flu illness last?     \_\_\_\_\_ day(s)  
9. How many days until you felt (your child felt or acted) back to your normal self? \_\_\_\_\_ day(s)

**If the patient is a child or a student ask the following questions. If not, skip to next the question.**

10. Did you (your child) miss any days of school due to the flu illness?    Yes    No (skip to Q11)    DK (skip to Q11)  
10a. How many days did you (your child) miss?     \_\_\_\_\_ days

**If the patient is an adult (>=18 years of age) ask the following question. If not, skip to the next section.**

11. Do you have a job outside your home?    Yes    No (skip to section VIII)    DK (skip to section VIII)  
11a. Did you miss any days of work?        Yes    No (skip to section VIII)    DK (skip to section VIII)  
11b. How many days did you miss?     \_\_\_\_\_ day(s)

**VIII. Transmission History** [Read to patient: *I'm going to ask some questions about others in your home who may have been ill and travel.*]

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

