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 ☐ Yes ☐ No ☐ Unk

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

Is sex known?
☐ Yes ☐ No
Sex: ☐ Male ☐ Female

Is ethnicity known?
☐ Yes ☐ No
Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Is race known? ☐ Yes ☐ No
Race:
☐ American Indian/ Alaska Native
☐ Asian or Pacific Islander
☐ Black or African American
☐ White
☐ Other _____

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? (Check all that apply)

☐ No underlying conditions
☐ Diabetes Mellitus
☐ Chronic kidney disease
☐ Asthma
☐ Chronic lung disease (non-asthma), specify_____
☐ Neurologic/neuromuscular disease
☐ Immunosuppressive condition **(complete section X)**
☐ 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: __ __/ __ __/ __ __ __ __
Where was the patient discharged to? ☐ Other hospital ☐ Home ☐ Hospice ☐ Rehabilitation facility ☐ Long term care facility ☐ Other

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:

☐ **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 (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

If yes, What was the name of the antiviral agent? ☐ Unknown
☐ 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? _____

IX. Additional Comments

Sender Information

First Name:	Last Name:	Date of Survey Completion: __ __/ __ __/ __ __ __ __
Institution Name:	Email Address:	Telephone Number:

X. Immunosuppression Details (check all that apply)

	☐ Solid Tumor Malignancy:	☐ Hematologic Malignancy:	☐ Receipt of Stem Cell Transplant	☐ Receipt of Solid Organ Transplant	☐ Autoimmune Disorder
Specify type(s)					
☐ Other condition (Lupus, Rheumatoid Arthritis, Crohns, etc) Specify Type (s):					☐ HIV/AIDS

IF ANTIVIRAL USE IS SELF REPORTED AND NOT VERIFIED BY MEDICAL OR PHARMACY RECORDS: *Thank you very much for taking the time to answer our questions. We would like to contact the health care provider you (your child) saw during the time of your illness to get more information on the treatment you received. Would it be OK for us to contact your doctor or health care provider (please circle selection)?* Y N Unsure

If yes, Please provide us with his or her information:
Name of facility and health care provider: _____
Phone number: _____

Case information to be collected from the health care provider
Hello, my name is _____ and I am calling from the state (or local) public health department in collaboration with the Centers for Disease Control and Prevention. I am calling to collect some information on a patient that was seen by you on about ___/___/___. The patient's name was _____ and date of birth was ___/___/___. We are collecting information on patients with influenza infection and would like to determine whether each case received antiviral treatment. I would like to ask you a few questions about this person's illness and any treatment with influenza antiviral medication, including Tamiflu.

Were antiviral agents prescribed to the patient for treatment *(please circle selection)*? Y N Don't Know

If yes, what medication was prescribed?	Dose (mg)	Date of Treatment Onset	Length of Prescribed Course (days)
i. Oseltamivir (Tamiflu)	_____	___/___/___	_____
ii. Zanamivir (Relenza)	_____	___/___/___	_____
iii. Other	_____	___/___/___	_____

Thank you very much for taking the time to answer our questions.