



Respiratory Disease Cluster Medical Record Form

Form Approved

OMB No. 0920-1011

This form is intended to be used as a supplement to the Novel Influenza A Case Report Form for patients with severe outcomes (hospitalization or death). Please complete all sections of this form for each patient with a severe outcome in addition to the Novel Influenza A Case Report Form. Once this form is complete, please submit it as an email attachment to CaseReportForms@cdc.gov or fax the completed form to 404-471-8119.

I. Reporter Information			
State/Territory _____	State/Territory Epi Case ID _____	State/Territory Lab ID _____	
Date form completed: ____/____/____		CDC Case ID _____	
Person completing form: _____	First Name: _____	Last Name: _____	Phone: _____ Email: _____
What are the source(s) of data for this report? (check all that apply) <input type="checkbox"/> Medical chart <input type="checkbox"/> Death certificate <input type="checkbox"/> Case report form <input type="checkbox"/> Other _____			
II. Patient Information and Medical Care			
1. Patient Date of birth: ____/____/____ (mm/dd/yyyy)			
2. Did the patient have an outpatient or ER medical care encounter during this illness?		<input type="checkbox"/> Yes, date: ____/____/____ (if multiple, list most recent)	<input type="checkbox"/> No <input type="checkbox"/> Unknown
3. Was the patient admitted to the hospital for this illness?		<input type="checkbox"/> Yes, date: ____/____/____ Time: ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> No <input type="checkbox"/> Unknown
4. Was patient hospitalized previously at another facility during this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Admission date: ____/____/____		Discharge date: ____/____/____ Was discharge from prior hospital a transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please note initial vital signs at hospital admission/ER presentation. Date taken: ____/____/____ (mm/dd/yyyy)			
5. Body Mass Index: _____	6. Height _____	<input type="checkbox"/> Inches <input type="checkbox"/> Height Unknown	7. Weight: _____ <input type="checkbox"/> Lbs. <input type="checkbox"/> Kg. <input type="checkbox"/> Weight Unknown
8. Blood Pressure ____/____	9. Respiratory Rate ____ per min	10. Heart Rate _____ beats/min	Temperature: ____ <input type="checkbox"/> °C <input type="checkbox"/> °F
11. O ₂ Sat ____%	12. Fraction of inspired oxygen ____ L <input type="checkbox"/> % <input type="checkbox"/>	13. Using: <input type="checkbox"/> O ₂ mask <input type="checkbox"/> room air <input type="checkbox"/> ventilator Specify O ₂ mask type: _____	
III. Illness Signs and Symptoms			
14. Please mark all signs and symptoms experienced or listed in the admission note.			Date of initial symptom onset: ____/____/____
<input type="checkbox"/> Fever (measured) highest temp. ____ <input type="checkbox"/> °C <input type="checkbox"/> °F Date of fever onset ____/____/____ (mm/dd/yyyy) <input type="checkbox"/> Feverishness (temperature not measured) <input type="checkbox"/> Wheezing <input type="checkbox"/> Altered mental status <input type="checkbox"/> Cough <input type="checkbox"/> Chills <input type="checkbox"/> Red or draining eyes (conjunctivitis) <input type="checkbox"/> With sputum (i.e., productive) <input type="checkbox"/> Headache <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Hemoptysis or bloody sputum <input type="checkbox"/> Excessive crying/fussiness (< 5 years old) <input type="checkbox"/> Vomiting <input type="checkbox"/> Sore throat <input type="checkbox"/> Fatigue/weakness <input type="checkbox"/> Diarrhea <input type="checkbox"/> Runny nose (rhinorrhea) <input type="checkbox"/> Muscle pain/myalgia <input type="checkbox"/> Rash, location _____ <input type="checkbox"/> Dyspnea/difficulty breathing Location _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Chest pain <input type="checkbox"/> Seizure _____			
IV. Patient Medical History			
15. Does the patient have any of the following pre-existing medical conditions? Check all that apply.			
15a. <input type="checkbox"/> Asthma/Reactive Airway Disease		15h. <input type="checkbox"/> Immunocompromising Condition	
15b. <input type="checkbox"/> Chronic Lung Disease		<input type="checkbox"/> HIV infection	
<input type="checkbox"/> Emphysema/COPD		<input type="checkbox"/> AIDS or CD4 count < 200	
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Stem cell transplant (e.g., bone marrow transplant)	
15c. <input type="checkbox"/> Chronic Metabolic Disease		<input type="checkbox"/> Organ transplant	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Cancer diagnosis within last 12 months (excluding non-melanoma skin cancer) Type: _____	
Insulin dependent <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Chemotherapy within last 12 months	
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Primary immune deficiency	
		<input type="checkbox"/> Chronic steroid therapy (within 2 weeks of admission)	
		<input type="checkbox"/> Other: _____	



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- 15d. **Blood disorders/Hemoglobinopathy**
- Sickle cell disease
 - Splenectomy/Asplenia
 - Other: _____

- 15i. **Renal Disease**
- Chronic kidney disease/chronic renal insufficiency
 - End stage renal disease
 - Dialysis
 - Nephrotic syndrome
 - Other: _____

- 15e. **Cardiovascular Disease (excluding hypertension)**
- Atherosclerotic cardiovascular disease
 - Cerebral vascular incident/Stroke
 - With disability Yes No Unknown
 - Congenital heart disease
 - Coronary artery disease (CAD)
 - Heart failure/Congestive heart failure
 - Other: _____

- 15j. **Other**
- Liver disease
 - Scoliosis
 - Obese or BMI ≥ 30
 - Morbidly obese or BMI ≥ 40
 - Down syndrome
 - Pregnant, gestational age in weeks: _____ Unknown
 - Post-partum (≤ 6 weeks)
 - Current smoker
 - Drug abuse
 - Alcohol abuse
 - Other: _____

- 15f. **Neuromuscular or Neurologic disorder**
- Muscular dystrophy
 - Multiple sclerosis
 - Mitochondrial disorder
 - Myasthenia gravis
 - Cerebral palsy
 - Dementia
 - Severe developmental delay
 - Plegias/Paralysis
 - Epilepsy/Seizure disorder
 - Other: _____

- 15g. **History of Guillain-Barré Syndrome**

PEDIATRIC CASES ONLY (<18 years old)

Abnormality of upper airway Yes No Unknown

History of febrile seizures Yes No Unknown

Premature Yes No Unknown
(gestational age < 37 weeks at birth for patients < 2yrs)

If yes, specify gestational age at birth in weeks: _____

Unknown gestational age at birth

V. Hematology and Serum Chemistries

16. Were any hematology or serum chemistries performed at hospital admission/presentation to care? Yes No (skip to Q. 35) Unknown (skip to Q. 35)

Please note initial values at admission/presentation to care. Date values were taken: ____/____/____ (mm/dd/yyyy)

17. White blood cell count (WBC) cells/mm ³	19. Hematocrit (Hct) %	24. Serum creatinine mg/dL
18. Differential: Neutrophils %	20. Platelets (Plt) 10 ³ /mm ³	25. Serum glucose mg/dL
Bands %	21. Sodium (Na) U/L	26. SGPT/ALT U/L
Lymphocytes %	21. Potassium (K) U/L	27. SGOT/AST U/L
Eosinophils %	22. Bicarbonate (HCO ₃) U/L	28. Total bilirubin mg/dL
	23. Serum albumin g/dL	29. C-reactive protein (CRP) mg/dL

Please describe other significant lab findings (e.g., CSF, protein).

31. Type of test	Specimen type	Date (mm/dd/yyyy)	Result
31.		____/____/____	
32.		____/____/____	
33.		____/____/____	
34.		____/____/____	

VI. Bacterial Pathogens – Sterile or respiratory site only

35. Was a pneumococcal urinary antigen test performed? Yes No Unknown

If yes, result: Positive Negative Unknown

35. Was a Legionella urinary antigen test performed? Yes No Unknown

If yes, result: Positive Negative Unknown

35. Were any bacterial culture tests performed (regardless of result)? Yes No (skip to Q.41) Unknown (skip to Q.41)

36. Indicate sites from which specimens were collected (check all that apply):

Blood Cerebrospinal fluid (CSF) Bronchoalveolar lavage (BAL)

Sputum Pleural fluid Endotracheal aspirate Other: _____

37. Was there culture confirmation of any bacterial infection? Yes No (skip to Q.41) Unknown (skip to Q.41)

38a. Positive Culture 1 collection date: _____ 38b. Specimen Blood Cerebrospinal fluid (CSF) Bronchoalveolar lavage



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____/____/____ (mm/dd/yyyy)	type: <input type="checkbox"/> Sputum <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Endotracheal aspirate <input type="checkbox"/> Other: _____ <input type="checkbox"/> S. aureus <input type="checkbox"/> S. pyogenes <input type="checkbox"/> S. pneumoniae <input type="checkbox"/> H. influenzae <input type="checkbox"/> Other: _____	(BAL)
38c. Pathogen(s) identified:		
38d. If <i>Staphylococcus aureus</i>, specify: <input type="checkbox"/> Methicillin resistant (MRSA) <input type="checkbox"/> Methicillin sensitive (MSSA) <input type="checkbox"/> Sensitivity unknown		
39a. Positive Culture 2 collection date: ____/____/____ (mm/dd/yyyy)	39b. Specimen type: <input type="checkbox"/> Sputum <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Endotracheal aspirate <input type="checkbox"/> Other: _____ <input type="checkbox"/> Blood <input type="checkbox"/> Cerebrospinal fluid (CSF) <input type="checkbox"/> Bronchoalveolar lavage (BAL)	
39c. Pathogen(s) identified: <input type="checkbox"/> S. aureus <input type="checkbox"/> S. pyogenes <input type="checkbox"/> S. pneumoniae <input type="checkbox"/> H. influenzae <input type="checkbox"/> Other: _____		
39d. If <i>Staphylococcus aureus</i>, specify: <input type="checkbox"/> Methicillin resistant (MRSA) <input type="checkbox"/> Methicillin sensitive (MSSA) <input type="checkbox"/> Sensitivity unknown		
40a. Positive Culture 3 collection date: ____/____/____ (mm/dd/yyyy)	40b. Specimen type: <input type="checkbox"/> Sputum <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Endotracheal aspirate <input type="checkbox"/> Other: _____ <input type="checkbox"/> Blood <input type="checkbox"/> Cerebrospinal fluid (CSF) <input type="checkbox"/> Bronchoalveolar lavage (BAL)	
40c. Pathogen(s) identified: <input type="checkbox"/> S. aureus <input type="checkbox"/> S. pyogenes <input type="checkbox"/> S. pneumoniae <input type="checkbox"/> H. influenzae <input type="checkbox"/> Other: _____		
40d. If <i>Staphylococcus aureus</i>, specify: <input type="checkbox"/> Methicillin resistant (MRSA) <input type="checkbox"/> Methicillin sensitive (MSSA) <input type="checkbox"/> Sensitivity unknown		

VII. Respiratory Viral Pathogens

41. Was the patient tested for any other viral pathogens? <input type="checkbox"/> Yes <input type="checkbox"/> No (skip to Q.42) <input type="checkbox"/> Unknown (skip to Q.42)					
	Positive	Negative	Not Tested/Unknown	Collection Date	Specimen Type
a. Respiratory syncytial virus/RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
b. Adenovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
c. Parainfluenza 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
d. Parainfluenza 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
e. Parainfluenza 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
f. Human metapneumovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
g. Rhinovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
h. Coronavirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
i. Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
j. Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____

VIII. Medications

42. Did the patient receive influenza antiviral medications during illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
	Date started	Date stopped	Frequency	Dose	
Oseltamivir (Tamiflu)	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Inhaled	____/____/____	____/____/____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID	
Zanamivir (Relenza)	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Inhaled	____/____/____	____/____/____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID	
Peramivir	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Inhaled	____/____/____	____/____/____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID	
Other influenza antiviral: _____	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Inhaled	____/____/____	____/____/____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID	
Other influenza antiviral: _____	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Inhaled	____/____/____	____/____/____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID	
43. Did the patient receive antibiotics during the illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
If yes, name	Date started	Date stopped	Dose		
	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	____/____/____	____/____/____		
	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	____/____/____	____/____/____		
	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	____/____/____	____/____/____		



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	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	___/___/___	___/___/___	
	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	___/___/___	___/___/___	
44. Did the patient receive steroids (excluding inhaled steroids or one time injections) or other immune modulating treatment specifically for this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
If yes, name		Date started	Date stopped	Dose
	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	___/___/___	___/___/___	
	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	___/___/___	___/___/___	
	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	___/___/___	___/___/___	
45. Additional treatment comments:				

IX. Chest Radiograph – Based on final impression/conclusion of the radiology report
Please include a copy of the radiology report with the form.

46. Did the patient have a chest x-ray within 3 days of admission?	<input type="checkbox"/> Yes, date ___/___/___	<input type="checkbox"/> No (skip to Q.52)	<input type="checkbox"/> Unknown (skip to Q.52)																												
47. If yes, was the chest x-ray abnormal?	<input type="checkbox"/> Yes, date ___/___/___	<input type="checkbox"/> No (skip to Q.52)	<input type="checkbox"/> Unknown (skip to Q.52)																												
48. For the abnormal chest x-ray, please transcribe the final impression/conclusion and check all that apply: Final impression/conclusion:																															
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	<input type="checkbox"/> Specify: _____																														
49. Did the patient have another chest x-ray within 3 days of admission? <input type="checkbox"/> Yes, date ___/___/___ <input type="checkbox"/> No (skip to Q.52) <input type="checkbox"/> Unknown (skip to Q.52)																															
50. If yes, was the chest x-ray abnormal? <input type="checkbox"/> Yes, date ___/___/___ <input type="checkbox"/> No (skip to Q.52) <input type="checkbox"/> Unknown (skip to Q.52)																															
51. For the abnormal chest x-ray, please transcribe the final impression/conclusion and check all that apply: Final impression/conclusion:																															
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	<input type="checkbox"/> Specify: _____																														

X. Chest CT or MRI – Based on final impression/conclusion of the radiology report
please include a copy of the radiology report with the form.

52. Did the patient have a chest CT/MRI scan within 3 days of admission?	<input type="checkbox"/> Yes, date ___/___/___	<input type="checkbox"/> No (skip to Q.56)	<input type="checkbox"/> Unknown (skip to Q.56)
52. If yes, please select one:	<input type="checkbox"/> CT: contrast	<input type="checkbox"/> CT: non-contrast	<input type="checkbox"/> MRI



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54. If yes, was the CT/MRI abnormal? Yes, date ____/____/____ No (skip to Q.56) Unknown (skip to Q.56)

55. For abnormal chest CT/ MRI, please check all that apply and please transcribe the final impression/conclusion:

Final impression/conclusion:

<input type="checkbox"/> Consolidation: →	<input type="checkbox"/> Single lobar infiltrate	<input type="checkbox"/> Multi-lobar infiltrate (unilateral)	<input type="checkbox"/> Multi-lobar infiltrate (bilateral)
	<input type="checkbox"/> Lobar or segmental collapse	<input type="checkbox"/> Cavitation/Abscess/Necrosis	<input type="checkbox"/> Round pneumonia
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<input type="checkbox"/> Other: →	<input type="checkbox"/> Air leak/Pneumothorax	<input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Chest wall invasion
	<input type="checkbox"/> Specify: _____		

XI. Clinical Course and Severity of Illness

56. At any time during the current illness, did the patient require or have the diagnosis of :

a. Admission to intensive care unit (ICU)		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Admission date: ____/____/____	Discharge date: ____/____/____			
If multiple admissions, 2 nd ICU admission date: ____/____/____	2 nd ICU discharge date: ____/____/____			
If more than 2 ICU admissions, please provide dates in the comments section (Q.66)				
b. Supplemental oxygen		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Date started: ____/____/____	Date stopped: ____/____/____			
c. Ventilatory support		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Check all that apply:	<input type="checkbox"/> Intubation	Date started: ____/____/____	Date stopped: ____/____/____	
	<input type="checkbox"/> ECMO	Date started: ____/____/____	Date stopped: ____/____/____	
	<input type="checkbox"/> CPAP	Date started: ____/____/____	Date stopped: ____/____/____	
	<input type="checkbox"/> BiPAP	Date started: ____/____/____	Date stopped: ____/____/____	
d. Vasopressor medications (e.g. dopamine, epinephrine)		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Date started: ____/____/____	Date stopped: ____/____/____			
e. Dialysis (Acute)		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Date started: ____/____/____	Date stopped: ____/____/____			
f. Resuscitation, CPR	<input type="checkbox"/> Yes, date started: ____/____/____	stopped: ____/____/____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
g. Acute respiratory distress syndrome (ARDS)	<input type="checkbox"/> Yes, date started: ____/____/____	stopped: ____/____/____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
h. Disseminated intravascular coagulopathy (DIC)	<input type="checkbox"/> Yes, date started: ____/____/____	stopped: ____/____/____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
i. Hemophagocytic syndrome	<input type="checkbox"/> Yes, date started: ____/____/____	stopped: ____/____/____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
j. Bronchiolitis	<input type="checkbox"/> Yes, date started: ____/____/____	stopped: ____/____/____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
k. Pneumonia	<input type="checkbox"/> Yes, date started: ____/____/____	stopped: ____/____/____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
l. Stroke (Acute)	<input type="checkbox"/> Yes, date started: ____/____/____	stopped: ____/____/____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
m. Sepsis	<input type="checkbox"/> Yes, date started: ____/____/____	stopped: ____/____/____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
n. Shock	<input type="checkbox"/> Yes, date started: ____/____/____	stopped: ____/____/____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Type: <input type="checkbox"/> hypovolemic <input type="checkbox"/> cardiogenic <input type="checkbox"/> septic <input type="checkbox"/> toxic				
o. Acute myocarditis	<input type="checkbox"/> Yes, date started: ____/____/____	stopped: ____/____/____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown



Ventura UAC Respiratory Disease Cluster Hospitalization Case Investigation Form

p. Acute myocardial dysfunction	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
q. Acute myocardial infarction	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
r. Seizures	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
s. Reye's syndrome	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
t. Acute encephalitis / encephalopathy	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
u. Guillain-Barre syndrome	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
v. Rhabdomyolysis	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
w. Acute liver impairment	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
x. Acute renal failure	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
y. Other, specify: _____	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___		
z. Other, specify: _____	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___		

XII. Outcomes

57. Did the patient die during this illness? Yes, date ___/___/___ No (skip to Q.62) Unknown (skip to Q.62)

58. What was the location of death? Home Hospital ER Hospice Other, specify _____

59. Did the patient have a DNR (do not resuscitate) order? Yes No Unknown

60. Was an autopsy performed? Yes (please attach a copy of the autopsy form to this report if available) No Unknown

61. What were the causes of death (immediate and underlying) in order of appearance on the death certificate or medical record?

1.	4.	7.
2.	5.	8.
3.	6.	9.

62. Has the patient been discharged from the hospital? Yes, date ___/___/___ No Unknown

63. If yes, please indicate to where: Home Other hospital Hospice Rehabilitation Facility
 Other long-term care facility Other, specify: _____ Unknown

63. If no, please indicate status: Hospitalized on ward Hospitalized in ICU Died

64. If patient was pregnant, please indicate pregnancy status at discharge or final update:

<input type="checkbox"/> Still pregnant	<input type="checkbox"/> Uncomplicated labor/delivery	<input type="checkbox"/> Complicated labor/delivery Describe _____	<input type="checkbox"/> Fetal loss Date ___/___/___
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64. If pregnancy resulted in delivery, please indicate neonatal outcome: Birth date: ___/___/___

<input type="checkbox"/> Healthy newborn	<input type="checkbox"/> Ill newborn, describe: _____	<input type="checkbox"/> Newborn died: Date ___/___/___	<input type="checkbox"/> Unknown
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65. Additional notes regarding discharge:

XIII. Additional Comments

66. Additional Comments:

