



Form Approved
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Hospitalized Case Investigation Form

Respiratory Illness

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 Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)



UAC Respiratory Disease Cluster Hospitalization Case Investigation Form

Alien Number _____

I. Reporter Information			
State/Territory _____		State/Territory Epi Case ID _____	
Date form completed: ____/____/____		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: ____/____/____	
		<input type="checkbox"/> No <input type="checkbox"/> Unknown	
3. Was the patient admitted to the hospital for this illness?		<input type="checkbox"/> Yes, date: ____/____/____	
		<input type="checkbox"/> No <input type="checkbox"/> Unknown	
		Time: ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
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		6. Height _____ <input type="checkbox"/> Inches <input type="checkbox"/> Height	
		7. Weight: _____ <input type="checkbox"/> Lbs. <input type="checkbox"/> Weight Unknown	
8. Blood Pressure ____/____		9. Respiratory Rate _____ per min	
		10. Heart Rate _____ beats/min	
		Temperature: ____°C ____°F	
11. O ₂ Sat ____%		12. Fraction of inspired oxygen ____% <input type="checkbox"/> L	
		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. ____°C ____°F		Date of fever onset ____/____/____ (mm/dd/yyyy)	
<input type="checkbox"/> Feverishness (temperature not measured)		<input type="checkbox"/> Wheezing	
<input type="checkbox"/> Cough		<input type="checkbox"/> Chills	
<input type="checkbox"/> With sputum (i.e., productive)		<input type="checkbox"/> Headache	
<input type="checkbox"/> Hemoptysis or bloody sputum		<input type="checkbox"/> Excessive crying/fussiness (< 5 years old)	
<input type="checkbox"/> Sore throat		<input type="checkbox"/> Fatigue/weakness	
<input type="checkbox"/> Runny nose (rhinorrhea)		<input type="checkbox"/> Muscle pain/myalgia	
<input type="checkbox"/> Dyspnea/difficulty breathing		Location _____	
<input type="checkbox"/> Chest pain		<input type="checkbox"/> Seizure	
		<input type="checkbox"/> Altered mental status	
		<input type="checkbox"/> Red or draining eyes (conjunctivitis)	
		<input type="checkbox"/> Abdominal pain	
		<input type="checkbox"/> Vomiting	
		<input type="checkbox"/> Diarrhea	
		<input type="checkbox"/> Rash, location _____	
		<input type="checkbox"/> Other _____	
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	
15d. <input type="checkbox"/> Blood disorders/Hemoglobinopathy		<input type="checkbox"/> Chronic steroid therapy (within 2 weeks of admission)	
<input type="checkbox"/> Sickle cell disease		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Splenectomy/Asplenia		15i. <input type="checkbox"/> Renal Disease	
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Chronic kidney disease/chronic renal insufficiency	
		<input type="checkbox"/> End stage renal disease	
		<input type="checkbox"/> Dialysis	
		<input type="checkbox"/> Nephrotic syndrome	
		<input type="checkbox"/> Other: _____	



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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: _____

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

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: _____

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 gestation 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:		20. Platelets (Plt)	10 ³ /mm ³	25. Serum glucose	mg/dL
Neutrophils	%	21. Sodium (Na)	U/L	26. SGPT/ALT	U/L
Bands	%	21. Potassium (K)	U/L	27. SGOT/AST	U/L
Lymphocytes	%	22. Bicarbonate (HCO₃)	U/L	28. Total bilirubin	mg/dL
Eosinophils	%	23. Serum albumin	g/dL	29. C-reactive protein (CRP)	mg/dL

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

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: ____/____/____ (mm/dd/yyyy) **38b. Specimen type:** Blood Cerebrospinal fluid (CSF) Bronchoalveolar lavage (BAL)

Sputum Pleural fluid Endotracheal aspirate Other: _____

38c. Pathogen(s) identified: *S. aureus* *S. pyogenes* *S. pneumoniae* *H. influenzae* Other: _____

38d. If *Staphylococcus aureus*, specify: Methicillin resistant (MRSA) Methicillin sensitive (MSSA) Sensitivity unknown

39a. Positive Culture 2 collection date: ____/____/____ (mm/dd/yyyy) **39b. Specimen type:** Blood Cerebrospinal fluid (CSF) Bronchoalveolar lavage (BAL)

Sputum Pleural fluid Endotracheal aspirate Other: _____

39c. Pathogen(s) identified: *S. aureus* *S. pyogenes* *S. pneumoniae* *H. influenzae* Other: _____

39d. If *Staphylococcus aureus*, specify: Methicillin resistant (MRSA) Methicillin sensitive (MSSA) Sensitivity unknown



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40a. Positive Culture 3 collection date: _____/_____/_____(mm/dd/yyyy)

40b. Specimen type: Blood Cerebrospinal fluid (CSF) Bronchoalveolar lavage (BAL)
 Sputum Pleural fluid Endotracheal aspirate Other: _____

40c. Pathogen(s) identified: *S. aureus* *S. pyogenes* *S. pneumoniae* *H. influenzae* Other: _____

40d. If *Staphylococcus aureus*, specify: Methicillin resistant (MRSA) Methicillin sensitive (MSSA) Sensitivity unknown

VII. Respiratory Viral Pathogens

41. Was the patient tested for any other viral pathogens? Yes No (skip to Q.42) 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? Yes No Unknown

	Date started	Date stopped	Frequency	Dose
Osetamivir (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? Yes No 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	____/____/____	____/____/____
	<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? Yes No 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? Yes, date ____/____/____ No (skip to Q.52) Unknown (skip to Q.52)

47. If yes, was the chest x-ray abnormal? Yes, date ____/____/____ No (skip to Q.52) 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"/> Consolidation: <input type="checkbox"/>	<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
<input type="checkbox"/> Other Infiltrate: <input type="checkbox"/>	<input type="checkbox"/> Alveolar (air space) disease	<input type="checkbox"/> Interstitial disease	<input type="checkbox"/> Mixed (airspace and interstitial) disease
<input type="checkbox"/> Pleural Effusion: <input type="checkbox"/>	<input type="checkbox"/> Unilateral	<input type="checkbox"/> Bilateral	
<input type="checkbox"/> Bronchiolitis: <input type="checkbox"/>	<input type="checkbox"/> Complicated	<input type="checkbox"/> Uncomplicated	
<input type="checkbox"/> Other: <input type="checkbox"/>	<input type="checkbox"/> Air leak/Pneumothorax	<input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Chest wall invasion
	<input type="checkbox"/> Specify: _____		

49. Did the patient have another chest x-ray within 3 days of admission? Yes, date ____/____/____ No (skip to Q.52) Unknown (skip to Q.52)

50. If yes, was the chest x-ray abnormal? Yes, date ____/____/____ No (skip to Q.52) 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:

<input type="checkbox"/> Consolidation: <input type="checkbox"/>	<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
<input type="checkbox"/> Other Infiltrate: <input type="checkbox"/>	<input type="checkbox"/> Alveolar (air space) disease	<input type="checkbox"/> Interstitial disease	<input type="checkbox"/> Mixed (airspace and interstitial) disease
<input type="checkbox"/> Pleural Effusion: <input type="checkbox"/>	<input type="checkbox"/> Unilateral	<input type="checkbox"/> Bilateral	
<input type="checkbox"/> Bronchiolitis: <input type="checkbox"/>	<input type="checkbox"/> Complicated	<input type="checkbox"/> Uncomplicated	
<input type="checkbox"/> Other: <input type="checkbox"/>	<input type="checkbox"/> Air leak/Pneumothorax	<input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Chest wall invasion
	<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? Yes, date ____/____/____ No (skip to Q.56) Unknown (skip to Q.56)

52. If yes, please select one: CT: contrast CT: non-contrast MRI

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"/>	<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
<input type="checkbox"/> Other Infiltrate: <input type="checkbox"/>	<input type="checkbox"/> Alveolar (air space) disease	<input type="checkbox"/> Interstitial disease	<input type="checkbox"/> Mixed (airspace and interstitial) disease
<input type="checkbox"/> Pleural Effusion: <input type="checkbox"/>	<input type="checkbox"/> Unilateral	<input type="checkbox"/> Bilateral	
<input type="checkbox"/> Bronchiolitis: <input type="checkbox"/>	<input type="checkbox"/> Complicated	<input type="checkbox"/> Uncomplicated	
<input type="checkbox"/> Other: <input type="checkbox"/>	<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) Yes No Unknown

Admission date: ____/____/____ Discharge date: ____/____/____

If multiple admissions, 2nd ICU admission date: ____/____/____ 2nd ICU discharge date: ____/____/____

If more than 2 ICU admissions, please provide dates in the comments section (Q.66)

b. Supplemental oxygen Yes No Unknown

Date started: ____/____/____ Date stopped: ____/____/____

c. Ventilatory support Yes No Unknown

Check all that apply: Intubation Date started: ____/____/____ Date stopped: ____/____/____

ECMO started: ____/____/____ Date stopped: ____/____/____

CPAP started: ____/____/____ Date stopped: ____/____/____



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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	<input type="checkbox"/> No		
o. Acute myocarditis	<input type="checkbox"/> Yes, date started: ____/____/____	stopped: ____/____/____	<input type="checkbox"/> No <input type="checkbox"/> Unknown
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: ____/____/____	<input type="checkbox"/> No <input type="checkbox"/> Unknown
z. Other, specify: _____	<input type="checkbox"/> Yes, date started: ____/____/____	stopped: ____/____/____	<input type="checkbox"/> No <input type="checkbox"/> Unknown

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:

Still pregnant Uncomplicated labor/delivery Complicated labor/delivery Fetal loss

Describe _____ Date ____/____/____

64. If pregnancy resulted in delivery, please indicate neonatal outcome: Birth date: ____/____/____

Healthy newborn Ill newborn, describe: _____ Newborn died: Date ____/____/____ Unknown

65. Additional notes regarding discharge:

XIII. Additional Comments

66. Additional Comments:



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