

## 2014-15 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form

A. Patient Data – THIS INFORMATION IS NOT SENT TO CDC			
Last Name:	First Name:	Phone Number 1:	Phone Number 2:
Street Address:		City:	Zip:
Chart Number:	Census Tract:	Address Type:	
Emergency Contact 1:		Emergency Contact Phone:	
PCP Name 1:	PCP Phone 1:	PCP Fax 1:	
PCP Name 2:	PCP Phone 2:	PCP Fax 2:	
Site Use 1:	Site Use 2:	Site Use 3:	
B. Reporter Information – THIS INFORMATION IS NOT SENT TO CDC			
1. Reporter Name: _____		2. Date Reported: ____/____/____	

C. Enrollment Information			
1. Case Classification: <input type="checkbox"/> Prospective Surveillance <input type="checkbox"/> Discharge Audit		2. Admission Type: <input type="checkbox"/> Hospitalization <input type="checkbox"/> Observation Only	
3. County: _____		4. State: _____	
5. Case Type: <input type="checkbox"/> Pediatric <input type="checkbox"/> Adult	6. Date of Birth: ____/____/____	7. Age: _____ <input type="checkbox"/> Years <input type="checkbox"/> Days (if < 1 month) <input type="checkbox"/> Months (if < 1 yr)	8. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
9. Race: <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 <input type="checkbox"/> Not specified		10. Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Not Specified	
11. Hospital ID Where Patient Treated: _____		11a. Admission Date: ____/____/____	
		11b. Discharge Date: ____/____/____	
12. Was patient transferred from another hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		12a. Transfer Hospital ID: _____	
12b. Transfer Hospital Admission Date: ____/____/____		12c. Transfer Date: ____/____/____	
13. Where did patient reside at the time of hospitalization?    Indicate TYPE of residence.			
<input type="checkbox"/> Private residence <input type="checkbox"/> Alcohol/Drug Abuse Treatment <input type="checkbox"/> Assisted living/Residential care <input type="checkbox"/> Group home/Retirement home <input type="checkbox"/> Homeless/Shelter <input type="checkbox"/> Hospitalized at birth <input type="checkbox"/> Jail/Prison <input type="checkbox"/> LTACH/Transitional Care (TCU) <input type="checkbox"/> Mental Hospital <input type="checkbox"/> Nursing home <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Hospice <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____			
13a. If resident of a facility, indicate NAME of facility: _____			

D. Influenza Testing Results			
1. Test 1: <input type="checkbox"/> Rapid <input type="checkbox"/> Molecular Assay <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology <input type="checkbox"/> Fluorescent Antibody <input type="checkbox"/> Method Unknown/Note Only			
1a. Result: <input type="checkbox"/> Flu A (no subtype) <input type="checkbox"/> Flu B (no genotype) <input type="checkbox"/> Flu A & B <input type="checkbox"/> Flu A/B (Not Distinguished) <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> H3 <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B, Yamagata <input type="checkbox"/> Flu B, Victoria <input type="checkbox"/> Negative <input type="checkbox"/> Unknown Type <input type="checkbox"/> Other, specify: _____			
1b. Specimen collection date: ____/____/____		1c. Testing facility ID: _____	
		1d. Specimen ID: _____	
2. Test 2: <input type="checkbox"/> Rapid <input type="checkbox"/> Molecular Assay <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology <input type="checkbox"/> Fluorescent Antibody <input type="checkbox"/> Method Unknown/Note Only			
2a. Result: <input type="checkbox"/> Flu A (no subtype) <input type="checkbox"/> Flu B (no genotype) <input type="checkbox"/> Flu A & B <input type="checkbox"/> Flu A/B (Not Distinguished) <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> H3 <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B, Yamagata <input type="checkbox"/> Flu B, Victoria <input type="checkbox"/> Negative <input type="checkbox"/> Unknown Type <input type="checkbox"/> Other, specify: _____			
2b. Specimen collection date: ____/____/____		2c. Testing facility ID: _____	
		2d. Specimen ID: _____	
3. Test 3: <input type="checkbox"/> Rapid <input type="checkbox"/> Molecular Assay <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology <input type="checkbox"/> Fluorescent Antibody <input type="checkbox"/> Method Unknown/Note Only			
3a. Result: <input type="checkbox"/> Flu A (no subtype) <input type="checkbox"/> Flu B (no genotype) <input type="checkbox"/> Flu A & B <input type="checkbox"/> Flu A/B (Not Distinguished) <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> H3 <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B, Yamagata <input type="checkbox"/> Flu B, Victoria <input type="checkbox"/> Negative <input type="checkbox"/> Unknown Type <input type="checkbox"/> Other, specify: _____			
3b. Specimen collection date: ____/____/____		3c. Testing facility ID: _____	
		3d. Specimen ID: _____	
4. Test 4: <input type="checkbox"/> Rapid <input type="checkbox"/> Molecular Assay <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology <input type="checkbox"/> Fluorescent Antibody <input type="checkbox"/> Method Unknown/Note Only			
4a. Result: <input type="checkbox"/> Flu A (no subtype) <input type="checkbox"/> Flu B (no genotype) <input type="checkbox"/> Flu A & B <input type="checkbox"/> Flu A/B (Not Distinguished) <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> H3 <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B, Yamagata <input type="checkbox"/> Flu B, Victoria <input type="checkbox"/> Negative <input type="checkbox"/> Unknown Type <input type="checkbox"/> Other, specify: _____			
4b. Specimen collection date: ____/____/____		4c. Testing facility ID: _____	
		4d. Specimen ID: _____	

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### E. Admission and Patient History

<b>1. Was patient discharged from any hospital within one week prior to the current admission date?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>2. Acute signs/symptoms at admission [within 2 weeks prior to positive flu test]:</b> (Write Y or N/Unk next to signs/symptoms)			
<input type="checkbox"/> Altered mental status/confusion	<input type="checkbox"/> Cough*	<input type="checkbox"/> Myalgia/muscle aches	<input type="checkbox"/> Shortness of breath/resp distress*
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Sore throat*
<input type="checkbox"/> Congested/runny nose*	<input type="checkbox"/> Fever/chills	<input type="checkbox"/> Rash	<input type="checkbox"/> Wheezing*
<input type="checkbox"/> Conjunctivitis/pink eye	<input type="checkbox"/> Headache	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other, non-respiratory
<b>3. Date of onset of acute respiratory symptoms [within 2 weeks prior to positive flu test]:</b> ___/___/___			<input type="checkbox"/> Unknown
<b>4. Date of onset of acute condition resulting in current hospitalization:</b> ___/___/___			<input type="checkbox"/> Unknown
<b>5. BMI:</b> <input type="checkbox"/> Unk	<b>6. Height:</b> <input type="checkbox"/> In <input type="checkbox"/> Cm <input type="checkbox"/> Unk	<b>7. Weight:</b> <input type="checkbox"/> Lbs <input type="checkbox"/> Kg <input type="checkbox"/> Unk	
<b>8. Smoker:</b> <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> No/Unknown	<b>9. Alcohol abuse:</b> <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> No/Unknown		
<b>10. Did patient have any of the following pre-existing medical conditions? Check all that apply.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>10a. Asthma/Reactive Airway Disease</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	<b>10h. History of Guillain-Barré Syndrome</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown		
<b>10b. Chronic Lung Disease</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	<b>10i. Immunocompromised Condition</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown		
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> AIDS or CD4 count < 200		
<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Cancer: current/in treatment or diagnosed in last 12 months		
<input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Complement deficiency		
<b>10c. Chronic Metabolic Disease</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	<input type="checkbox"/> HIV Infection		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Immunoglobulin deficiency		
<input type="checkbox"/> Thyroid dysfunction	<input type="checkbox"/> Immunosuppressive therapy		
<input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Organ transplant		
<b>10d. Blood disorders/Hemoglobinopathy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	<input type="checkbox"/> Stem cell transplant (e.g., bone marrow transplant)		
<input type="checkbox"/> Sickle cell disease	<input type="checkbox"/> Steroid therapy (taken within 2 weeks of admission)		
<input type="checkbox"/> Splenectomy/Asplenia	<input type="checkbox"/> Other, specify _____		
<input type="checkbox"/> Thrombocytopenia	<b>10j. Renal Disease</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown		
<input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Chronic kidney disease/chronic renal insufficiency		
<b>10e. Cardiovascular Disease</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	<input type="checkbox"/> End stage renal disease/Dialysis		
<input type="checkbox"/> Atherosclerotic cardiovascular disease (ASCVD)	<input type="checkbox"/> Glomerulonephritis		
<input type="checkbox"/> Cerebral vascular incident/Stroke	<input type="checkbox"/> Nephrotic syndrome		
<input type="checkbox"/> Congenital heart disease	<input type="checkbox"/> Other, specify _____		
<input type="checkbox"/> Coronary artery disease (CAD)	<b>10k. Other</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown		
<input type="checkbox"/> Heart failure/CHF	<input type="checkbox"/> Intravenous drug use		
<input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Liver disease (e.g., cirrhosis, chronic hepatitis, hepatitis C)		
<b>10f. Neuromuscular disorder</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	<input type="checkbox"/> Systemic lupus erythematosus/SLE/Lupus		
<input type="checkbox"/> Duchenne muscular dystrophy	<input type="checkbox"/> Morbidly obese (ADULTS ONLY)		
<input type="checkbox"/> Muscular dystrophy	<input type="checkbox"/> Obese		
<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Pregnant		
<input type="checkbox"/> Mitochondrial disorder	<input type="checkbox"/> If pregnant, specify gestational age in weeks: _____		
<input type="checkbox"/> Myasthenia gravis	<input type="checkbox"/> Unknown gestational age		
<input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Post-partum (two weeks or less)		
<b>10g. Neurologic disorder</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	<input type="checkbox"/> Other, specify _____		
<input type="checkbox"/> Cerebral palsy	<b>10l. PEDIATRIC CASES ONLY</b>		
<input type="checkbox"/> Cognitive dysfunction	<b>Abnormality of upper airway</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown		
<input type="checkbox"/> Dementia	<b>History of febrile seizures</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown		
<input type="checkbox"/> Developmental delay	<b>Long-term aspirin therapy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown		
<input type="checkbox"/> Down syndrome	<b>Premature</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown		
<input type="checkbox"/> Plegias/Paralysis	(gestation age < 37 weeks at birth for patients < 2yrs)		
<input type="checkbox"/> Seizure/Seizure disorder	If yes, specify gestational age at birth in weeks: _____		
<input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Unknown gestational age at birth		

\*These are considered acute respiratory symptoms

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### F. Intensive Care Unit and Interventions

**1. Was the patient admitted to an intensive care unit (ICU)?**  Yes  No  Unknown  
**1a. Number of ICU Admissions:** \_\_\_\_\_  Unknown  
**1b. Date of first ICU Admission:** \_\_\_/\_\_\_/\_\_\_  Unknown    **1c. Date of first ICU Discharge:** \_\_\_/\_\_\_/\_\_\_  Unknown

**2. Did patient receive mechanical ventilation?**  Yes  No  Unknown

**3. Did patient receive extracorporeal membrane oxygenation (ECMO or 'on bypass')?**  Yes  No  Unknown

### G. Bacterial Pathogens – Sterile or respiratory site only

**1. Were any bacterial culture tests performed with a collection date within three days of admission?**  Yes  No  Unknown

**2. If yes, was there a positive culture for a bacterial pathogen?**  Yes  No  Unknown

**3a. If yes, specify Pathogen 1:** \_\_\_\_\_    **3b. Date of culture:** \_\_\_/\_\_\_/\_\_\_

**3c. Site where pathogen identified:**  Blood     Cerebrospinal fluid (CSF)     Bronchoalveolar lavage (BAL)  
 Sputum     Pleural fluid     Endotracheal aspirate     Other, specify: \_\_\_\_\_

**3d. If Staphylococcus aureus, specify:**  Methicillin resistant (MRSA)     Methicillin sensitive (MSSA)     Sensitivity unknown

**3e. If Haemophilus influenzae, specify if type B:**  Yes     No     Unknown

**3f. If Neisseria meningitidis, specify serogroup:**  B     C     Y     Other, specify: \_\_\_\_\_  Unknown

**4a. Specify Pathogen 2:** \_\_\_\_\_    **4b. Date of culture:** \_\_\_/\_\_\_/\_\_\_

**4c. Site where pathogen identified:**  Blood     Cerebrospinal fluid (CSF)     Bronchoalveolar lavage (BAL)  
 Sputum     Pleural fluid     Endotracheal aspirate     Other, specify: \_\_\_\_\_

**4d. If Staphylococcus aureus, specify:**  Methicillin resistant (MRSA)     Methicillin sensitive (MSSA)     Sensitivity unknown

**4e. If Haemophilus influenzae, specify if type B:**  Yes     No     Unknown

**4f. If Neisseria meningitidis, specify serogroup:**  B     C     Y     Other, specify: \_\_\_\_\_  Unknown

### H. Viral Pathogens

**1. Was patient tested for any of the following viral respiratory pathogens within 3 days of admission?**  Yes  No  Unknown

1a. Respiratory syncytial virus/RSV	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	<b>Date:</b> ___/___/___
1b. Adenovirus	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	<b>Date:</b> ___/___/___
1c. Parainfluenza 1	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	<b>Date:</b> ___/___/___
1d. Parainfluenza 2	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	<b>Date:</b> ___/___/___
1e. Parainfluenza 3	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	<b>Date:</b> ___/___/___
1f. Parainfluenza 4	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	<b>Date:</b> ___/___/___
1g. Human metapneumovirus	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	<b>Date:</b> ___/___/___
1h. Rhinovirus/Enterovirus	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	<b>Date:</b> ___/___/___
1i. Coronavirus (type): _____	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	<b>Date:</b> ___/___/___

### I. Influenza Treatment

**1. Did patient receive antiviral medication treatment for influenza during the course of this illness?**  Yes  No  Unknown

**2a. Treatment 1:**  Oseltamivir (Tamiflu)     Zanamivir (Relenza)     Other, specify: \_\_\_\_\_  
 Amantadine (Symmetrel)     Rimantadine (Flumadine)     Unknown

**2b. Method of Administration:**  Oral     Intravenous (IV)     Inhaled     Unknown

**2c. Start Date:** \_\_\_/\_\_\_/\_\_\_    **2d. End Date:** \_\_\_/\_\_\_/\_\_\_    **2e. Dose:** \_\_\_\_\_    **2f. Frequency:** \_\_\_\_\_  
 Start Date Unknown     End Date Unknown     Dose Unknown     Frequency Unknown

**3a. Treatment 2:**  Oseltamivir (Tamiflu)     Zanamivir (Relenza)     Other, specify: \_\_\_\_\_  
 Amantadine (Symmetrel)     Rimantadine (Flumadine)     Unknown

**3b. Method of Administration:**  Oral     Intravenous (IV)     Inhaled     Unknown

**3c. Start Date:** \_\_\_/\_\_\_/\_\_\_    **3d. End Date:** \_\_\_/\_\_\_/\_\_\_    **3e. Dose:** \_\_\_\_\_    **3f. Frequency:** \_\_\_\_\_  
 Start Date Unknown     End Date Unknown     Dose Unknown     Frequency Unknown

**4a. Treatment 3:**  Oseltamivir (Tamiflu)     Zanamivir (Relenza)     Other, specify: \_\_\_\_\_  
 Amantadine (Symmetrel)     Rimantadine (Flumadine)     Unknown

**4b. Method of Administration:**  Oral     Intravenous (IV)     Inhaled     Unknown

**4c. Start Date:** \_\_\_/\_\_\_/\_\_\_    **4d. End Date:** \_\_\_/\_\_\_/\_\_\_    **4e. Dose:** \_\_\_\_\_    **4f. Frequency:** \_\_\_\_\_  
 Start Date Unknown     End Date Unknown     Dose Unknown     Frequency Unknown

**5a. Treatment 4:**  Oseltamivir (Tamiflu)     Zanamivir (Relenza)     Other, specify: \_\_\_\_\_  
 Amantadine (Symmetrel)     Rimantadine (Flumadine)     Unknown

**5b. Method of Administration:**  Oral     Intravenous (IV)     Inhaled     Unknown

**5c. Start Date:** \_\_\_/\_\_\_/\_\_\_    **5d. End Date:** \_\_\_/\_\_\_/\_\_\_    **5e. Dose:** \_\_\_\_\_    **5f. Frequency:** \_\_\_\_\_  
 Start Date Unknown     End Date Unknown     Dose Unknown     Frequency Unknown

**6. Additional Treatment Comments:** \_\_\_\_\_

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### J. Chest Radiograph – Based on radiology report only

1. Was a chest x-ray taken *within 3 days of admission*?     Yes     No     Unknown
2. Were any of these chest x-rays abnormal?     Yes     No     Unknown
- 2a. Date of first abnormal chest x-ray:    \_\_\_/\_\_\_/\_\_\_
- 2b. 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 infiltrate         |
| <input type="checkbox"/> Cannot rule out pneumonia  | <input type="checkbox"/> ARDS (acute respiratory distress syndrome) | <input type="checkbox"/> Other                    |

### K. Discharge Summary

1. Did the patient have any of the following diagnoses at discharge (check all that apply)?
- |                                   |                              |                             |                                  |  |                              |                             |                                  |
|-----------------------------------|------------------------------|-----------------------------|----------------------------------|--|------------------------------|-----------------------------|----------------------------------|
| Pneumonia                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | Stroke (CVI)                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Guillain-Barré syndrome           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | Acute myocarditis                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Acute encephalopathy/encephalitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | Acute respiratory distress syndrome (ARDS) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Seizures                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | Bronchiolitis                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Reye's syndrome                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | Hemophagocytic syndrome                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
2. What was the outcome of the patient?     Alive     Deceased     Unknown
- 2a. If discharged alive, please indicate to where:
- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Private residence  | <input type="checkbox"/> Alcohol/Drug Abuse Treatment | <input type="checkbox"/> Assisted living/Residential Care | <input type="checkbox"/> Group home/Retirement home    |
| <input type="checkbox"/> Home with Services | <input type="checkbox"/> Homeless/Shelter             | <input type="checkbox"/> Jail/Prison                      | <input type="checkbox"/> LTACH/Transitional Care (TCU) |
| <input type="checkbox"/> Nursing home       | <input type="checkbox"/> Rehabilitation Facility      | <input type="checkbox"/> Hospice                          | <input type="checkbox"/> Unknown                       |
3. If patient was pregnant on admission, indicate pregnancy status at discharge:     Still pregnant     No longer pregnant     Unknown
- 3a. If patient was pregnant on admission but no longer pregnant at discharge, indicate pregnancy outcome at discharge:
- |                                      |                                      |                                       |  |                                   |                                  |
|--------------------------------------|--------------------------------------|---------------------------------------|--|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Ill newborn | <input type="checkbox"/> Newborn died | <input type="checkbox"/> Healthy newborn | <input type="checkbox"/> Abortion | <input type="checkbox"/> Unknown |
|--------------------------------------|--------------------------------------|---------------------------------------|--|-----------------------------------|----------------------------------|
4. Additional notes regarding discharge: \_\_\_\_\_

### L. ICD-9 or ICD-10 Discharge Diagnoses – To be recorded in order of appearance

Version: <input type="checkbox"/> ICD-9 <input type="checkbox"/> ICD-10	1.	4.	7.
	2.	5.	8.
	3.	6.	9.

### M. Vaccination History

- Specify vaccination status and date(s) by source:
- |  |   |   |  |                                       |                                      |
|--|---|---|--|---------------------------------------|--------------------------------------|
| <b>1. Medical Chart:</b>   | <input type="checkbox"/> Yes, full date known | <input type="checkbox"/> Yes, specific date unknown | <input type="checkbox"/> No                  | <input type="checkbox"/> Unknown      | <input type="checkbox"/> Not Checked |
| <b>1a. If yes, specify dosage date information:</b>  | 1) ___/___/___                                | <input type="checkbox"/> Date Unknown               | 2) (Pediatrics Only) ___/___/___             | <input type="checkbox"/> Date Unknown |                                      |
| <b>1b. If patient &lt; 9 yrs, specify vaccine type:</b>  | <input type="checkbox"/> Injected Vaccine     | <input type="checkbox"/> Nasal Spray/FluMist        | <input type="checkbox"/> Combination of both | <input type="checkbox"/> Unknown type |                                      |
| <b>2. Vaccine Registry:</b>  | <input type="checkbox"/> Yes, full date known | <input type="checkbox"/> Yes, specific date unknown | <input type="checkbox"/> No                  | <input type="checkbox"/> Unknown      | <input type="checkbox"/> Not Checked |
| <b>2a. If yes, specify dosage date information:</b>  | 1) ___/___/___                                | <input type="checkbox"/> Date Unknown               | 2) (Pediatrics Only) ___/___/___             | <input type="checkbox"/> Date Unknown |                                      |
| <b>2b. If patient &lt; 9 yrs, specify vaccine type:</b>  | <input type="checkbox"/> Injected Vaccine     | <input type="checkbox"/> Nasal Spray/FluMist        | <input type="checkbox"/> Combination of both | <input type="checkbox"/> Unknown type |                                      |
| <b>3. Primary Care Provider / Long-term Care Facility:</b>   | <input type="checkbox"/> Yes, full date known | <input type="checkbox"/> Yes, specific date unknown | <input type="checkbox"/> No                  | <input type="checkbox"/> Unknown      | <input type="checkbox"/> Not Checked |
| <b>3a. If yes, specify dosage date information:</b>  | 1) ___/___/___                                | <input type="checkbox"/> Date Unknown               | 2) (Pediatrics Only) ___/___/___             | <input type="checkbox"/> Date Unknown |                                      |
| <b>3b. If patient &lt; 9 yrs, specify vaccine type:</b>  | <input type="checkbox"/> Injected Vaccine     | <input type="checkbox"/> Nasal Spray/FluMist        | <input type="checkbox"/> Combination of both | <input type="checkbox"/> Unknown type |                                      |
| <b>4. Interview:</b>   | <input type="checkbox"/> Yes, full date known | <input type="checkbox"/> Yes, specific date unknown | <input type="checkbox"/> No                  | <input type="checkbox"/> Unknown      | <input type="checkbox"/> Not Checked |
| <input type="checkbox"/> Patient <input type="checkbox"/> Proxy  |   |   |  |                                       |                                      |
| <b>4a. If yes, specify dosage date information:</b>  | 1) ___/___/___                                | <input type="checkbox"/> Date Unknown               | 2) (Pediatrics Only) ___/___/___             | <input type="checkbox"/> Date Unknown |                                      |
| <b>4b. If patient &lt; 9 yrs, specify vaccine type:</b>  | <input type="checkbox"/> Injected Vaccine     | <input type="checkbox"/> Nasal Spray/FluMist        | <input type="checkbox"/> Combination of both | <input type="checkbox"/> Unknown type |                                      |
| <b>5. If patient &lt; 9 yrs, did patient receive any seasonal influenza vaccine in previous seasons?</b> | <input type="checkbox"/> Yes                  | <input type="checkbox"/> No                         | <input type="checkbox"/> Unknown             |                                       |                                      |

### N. Miscellaneous

1. Additional Comments: