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](mailto:CaseReportForms@cdc.gov) or fax the completed form to 404-471-8119.

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| **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) | | 🞎 Medical chart | | 🞎 Death certificate | | | | 🞎 Case report form | | 🞎 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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?** | | 🞎 Yes, date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_  (if multiple, list most recent) | | 🞎 No | | | 🞎 Unknown | | |
| **3. Was the patient admitted to the hospital for this illness?** | | 🞎 Yes, date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_  Time: \_\_\_\_:\_\_\_\_ 🞎 AM 🞎 PM | | 🞎 No | | | 🞎 Unknown | | |
| **4. Was patient hospitalized previously at another facility during this illness?** | | | | | 🞎 Yes | 🞎 No | 🞎 Unknown | | |
| Admission date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ | Discharge date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ | | Was discharge from prior hospital a transfer? | | | | | 🞎 Yes | 🞎 No |

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| **Please note initial vital signs at hospital admission/ER presentation.** Date taken: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (mm/dd/yyyy) | | | | | | | | | | | | | | |
| **5.** Body Mass  Index: | \_\_\_\_\_\_\_\_ | | **6.** Height | | \_\_\_\_\_\_\_\_ | 🞎 Inches  🞎 Cm | 🞎 Height Unknown | | | **7.** Weight: | \_\_\_\_\_\_\_\_\_ | | 🞎 Lbs.  🞎 Kg | 🞎 Weight Unknown |
| **8.** Blood Pressure \_\_\_\_ /\_\_\_\_\_ | | | | **9.** Respiratory Rate \_\_\_\_\_\_ per min | | | | **10.** Heart Rate \_\_\_\_\_\_\_\_\_\_\_ beats/min | | | | Temperature: \_\_\_\_\_\_ 🞎°C 🞎°F | | |
| **11.** O2 Sat \_\_\_\_\_\_% | | **12.** Fraction of inspired oxygen \_\_\_\_\_\_ 🞎 % 🞎 L | | | | | | | **13.** Using: 🞎 O2 mask 🞎 room air 🞎 ventilator  Specify O2 mask type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |

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| **III. Illness Signs and Symptoms** | | | | |
| **14. Please mark all signs and symptoms experienced or listed in the admission note.** | | | Date of initial symptom onset: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | |
| 🞎 Fever (measured) highest temp. \_\_\_\_\_\_ 🞎°C 🞎°F | | Date of fever onset \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (mm/dd/yyyy) | | |
| 🞎 Feverishness (temperature not measured) | 🞎 Wheezing | | | 🞎 Altered mental status |
| 🞎 Cough | 🞎 Chills | | | 🞎 Red or draining eyes (conjunctivitis) |
| 🞎 With sputum (i.e., productive) | 🞎 Headache | | | 🞎 Abdominal pain |
| 🞎 Hemoptysis or bloody sputum | 🞎 Excessive crying/fussiness (< 5 years old) | | | 🞎 Vomiting |
| 🞎 Sore throat | 🞎 Fatigue/weakness | | | 🞎 Diarrhea |
| 🞎 Runny nose (rhinorrhea) | 🞎 Muscle pain/myalgia | | | 🞎 Rash, location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞎 Dyspnea/difficulty breathing | Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | 🞎 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞎 Chest pain | 🞎 Seizure | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **IV. Patient Medical History** | | | | | | | | | | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **15. Does the patient have any of the following pre-existing medical conditions? Check all that apply.** | | | | | | |  | | | | | | | 15a. 🞎 **Asthma/Reactive Airway Disease** | 15h. 🞎 **Immunocompromising Condition** | | | | | |  | 🞎 HIV infection | | | | | | 15b. 🞎 **Chronic Lung Disease** | 🞎 AIDS or CD4 count < 200 | | | | | | 🞎 Emphysema/COPD | 🞎 Stem cell transplant (e.g., bone marrow transplant) | | | | | | 🞎 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 Organ transplant | | | | | |  | 🞎 Cancer diagnosis within last 12 months (excluding non- melanoma skin cancer) Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | 15c. 🞎 **Chronic Metabolic Disease** | 🞎 Chemotherapy within last 12 months | | | | | | 🞎 Diabetes | 🞎 Primary immune deficiency | | | | | | Insulin dependent 🞎 Yes 🞎 No 🞎 Unknown | 🞎 Chronic steroid therapy (within 2 weeks of admission) | | | | | | 🞎 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |  | | | | | | 15d. 🞎 **Blood disorders/Hemoglobinopathy** | 15i. 🞎 **Renal Disease** | | | | | | 🞎 Sickle cell disease | 🞎 Chronic kidney disease/chronic renal insufficiency | | | | | | 🞎 Splenectomy/Asplenia | 🞎 End stage renal disease | | | | | | 🞎 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 Dialysis | | | | | |  | 🞎 Nephrotic syndrome | | | | | |  | 🞎 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |  | | | | | | 15e. 🞎 **Cardiovascular Disease (excluding hypertension)** | 15j. 🞎 **Other** | | | | | | 🞎 Atherosclerotic cardiovascular disease | 🞎 Liver disease | | | | | | 🞎 Cerebral vascular incident/Stroke | 🞎 Scoliosis | | | | | | With disability 🞎 Yes 🞎 No 🞎 Unknown | 🞎 Obese or BMI ≥ 30 | | | | | | 🞎 Congenital heart disease | 🞎 Morbidly obese or BMI ≥ 40 | | | | | | 🞎 Coronary artery disease (CAD) | 🞎 Down syndrome | | | | | | 🞎 Heart failure/Congestive heart failure | 🞎 Pregnant, gestational age in weeks: \_\_\_\_\_ | | | 🞎 Unknown | | | 🞎 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 Post-partum (≤ 6 weeks) | | | | | |  | 🞎 Current smoker | | | | | | 15f. 🞎 **Neuromuscular or Neurologic disorder** | 🞎 Drug abuse | | | | | | 🞎 Muscular dystrophy | 🞎 Alcohol abuse | | | | | | 🞎 Multiple sclerosis | 🞎 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | 🞎 Mitochondrial disorder | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | 🞎 Myasthenia gravis | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | 🞎 Cerebral palsy |  | | | | | | 🞎 Dementia | PEDIATRIC CASES ONLY (<18 years old) | | | | | | 🞎 Severe developmental delay | **Abnormality of upper airway** | 🞎 Yes | 🞎 No | | 🞎 Unknown | | 🞎 Plegias/Paralysis | **History of febrile seizures** | 🞎 Yes | 🞎 No | | 🞎 Unknown | | 🞎 Epilepsy/Seizure disorder | **Premature** | 🞎 Yes | 🞎 No | | 🞎 Unknown | | 🞎 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | (gestational age < 37 weeks at birth for patients < 2yrs) | | | | | |  | If yes, specify gestation age at birth in weeks: \_\_\_\_\_\_\_\_ | | | | | | 15g. 🞎 **History of Guillain-Barré Syndrome** | 🞎 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/mm3 | **19.** Hematocrit (Hct) | | | % | | | **24.** Serum creatinine | | | mg/dL | |
| **18.** Differential: | Neutrophils | | % | **20.** Platelets (Plt) | | | 103/mm3 | | | **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 (HCO3) | | | 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).** | | | | | | | | | | | | | | |
| Type of test | | Specimen type | | | Date (mm/dd/yyyy) | | | Result | | | | | | |
| **31.** | |  | | | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | |  | | | | | | |
| **32.** | |  | | | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | |  | | | | | | |
| **33.** | |  | | | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | |  | | | | | | |
| **34.** | |  | | | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | |  | | | | | | |

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| **VI. Bacterial Pathogens** *– Sterile or respiratory site only* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **35. Was a pneumococcalurinary 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 | | | | | | |
| **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 | | | 🞎 | | | | | | | | | 🞎 | | | | 🞎 | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| b. Adenovirus | | | 🞎 | | | | | | | | | 🞎 | | | | 🞎 | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| c. Parainfluenza 1 | | | 🞎 | | | | | | | | | 🞎 | | | | 🞎 | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| d. Parainfluenza 2 | | | 🞎 | | | | | | | | | 🞎 | | | | 🞎 | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| e. Parainfluenza 3 | | | 🞎 | | | | | | | | | 🞎 | | | | 🞎 | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| f. Human metapneumovirus | | | 🞎 | | | | | | | | | 🞎 | | | | 🞎 | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| g. Rhinovirus | | | 🞎 | | | | | | | | | 🞎 | | | | 🞎 | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| h. Coronavirus | | | 🞎 | | | | | | | | | 🞎 | | | | 🞎 | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| i. Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | 🞎 | | | | | | | | | 🞎 | | | | 🞎 | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| j. Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | 🞎 | | | | | | | | | 🞎 | | | | 🞎 | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| **VIII. Medications** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **42. Did the patient receive influenza antiviral medications during illness?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 🞎 **Yes** | | | | | | | | | 🞎 **No** | | | 🞎 **Unknown** | | | |
|  | | | | | | | | | | | | | | | | | | | | | Date started | | | | | | | | | | | | | Date stopped | | | | | | | | | | | | Frequency | | | | | | | Dose |
| Oseltamivir (Tamiflu) | | | | | 🞎 PO 🞎 IV 🞎 Inhaled | | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | 🞎 QD 🞎 BID 🞎 TID | | | | | | |  |
| Zanamivir (Relenza) | | | | | 🞎 PO 🞎 IV 🞎 Inhaled | | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | 🞎 QD 🞎 BID 🞎 TID | | | | | | |  |
| Peramivir | | | | | 🞎 PO 🞎 IV 🞎 Inhaled | | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | 🞎 QD 🞎 BID 🞎 TID | | | | | | |  |
| Other influenza antiviral:\_\_\_\_\_\_\_\_\_\_\_ | | | | | 🞎 PO 🞎 IV 🞎 Inhaled | | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | 🞎 QD 🞎 BID 🞎 TID | | | | | | |  |
| Other influenza antiviral:\_\_\_\_\_\_\_\_\_\_\_ | | | | | 🞎 PO 🞎 IV 🞎 Inhaled | | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | 🞎 QD 🞎 BID 🞎 TID | | | | | | |  |
| **43. Did the patient receive antibiotics during the illness?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 🞎 **Yes** | | | | | | | | 🞎 **No** | | | 🞎 **Unknown** | | | |
| If yes, name | | | | | | | | | | | | | | | | | | | | | | | | Date started | | | | | | | | | | | | | | | Date stopped | | | | | | | | | | | | | Dose | |
|  | | | | | | | | | | 🞎 PO 🞎 IV 🞎 IM | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | |  | |
|  | | | | | | | | | | 🞎 PO 🞎 IV 🞎 IM | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | |  | |
|  | | | | | | | | | | 🞎 PO 🞎 IV 🞎 IM | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | |  | |
|  | | | | | | | | | | 🞎 PO 🞎 IV 🞎 IM | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | |  | |
|  | | | | | | | | | | 🞎 PO 🞎 IV 🞎 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 | | |
|  | | | | | | | | | | | 🞎 PO 🞎 IV 🞎 IM | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | |  | | |
|  | | | | | | | | | | | 🞎 PO 🞎 IV 🞎 IM | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | | | |  | | |
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| **45. Additional treatment comments:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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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| 🞎 **Consolidation: 🡪** | 🞎 Single lobar infiltrate | | | | | | | 🞎 Multi-lobar infiltrate (unilateral) | | | | | | 🞎 Multi-lobar infiltrate (bilateral) | | | |
|  | 🞎 Lobar or segmental collapse | | | | | | | 🞎 Cavitation/Abscess/Necrosis | | | | | | 🞎 Round pneumonia | | | |
| 🞎 **Other Infiltrate: 🡪** | 🞎 Alveolar (air space) disease | | | | | | | 🞎 Interstitial disease | | | | | | 🞎 Mixed (airspace and interstitial) disease | | | |
| 🞎 **Pleural Effusion: 🡪** | 🞎 Unilateral | | | | | | | 🞎 Bilateral | | | | | | |  | | |
| 🞎 **Bronchiolitis: 🡪** | 🞎 Complicated | | | | | | | 🞎 Uncomplicated | | | | | | |  | | |
| 🞎 **Other: 🡪** | 🞎 Air leak/Pneumothorax | | | | | | | 🞎 Lymphadenopathy | | | | | 🞎 Chest wall invasion | | | | |
|  | 🞎 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: | | | | | | | | | | | | | | | | | |
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| 🞎 **Consolidation: 🡪** | | 🞎 Single lobar infiltrate | | | | | | 🞎 Multi-lobar infiltrate (unilateral) | | | | | 🞎 Multi-lobar infiltrate (bilateral) | | | | |
|  | | 🞎 Lobar or segmental collapse | | | | | | 🞎 Cavitation/Abscess/Necrosis | | | | | 🞎 Round pneumonia | | | | |
| 🞎 **Other Infiltrate: 🡪** | | 🞎 Alveolar (air space) disease | | | | | | 🞎 Interstitial disease | | | | | 🞎 Mixed (airspace and interstitial) disease | | | | |
| 🞎 **Pleural Effusion: 🡪** | | 🞎 Unilateral | | | | | | 🞎 Bilateral | | | | |  | | | | |
| 🞎 **Bronchiolitis: 🡪** | | 🞎 Complicated | | | | | | 🞎 Uncomplicated | | | | |  | | | | |
| 🞎 **Other: 🡪** | | 🞎 Air leak/Pneumothorax | | | | | | 🞎 Lymphadenopathy | | | | | 🞎 Chest wall invasion | | | | |
|  | | 🞎 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: | | | | | | | | | | | | | | | | | |
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| 🞎 **Consolidation: 🡪** | 🞎 Single lobar infiltrate | | | | | | | 🞎 Multi-lobar infiltrate (unilateral) | | | | | | 🞎 Multi-lobar infiltrate (bilateral) | | | |
|  | 🞎 Lobar or segmental collapse | | | | | | | 🞎 Cavitation/Abscess/Necrosis | | | | | | 🞎 Round pneumonia | | | |
| 🞎 **Other Infiltrate: 🡪** | 🞎 Alveolar (air space) disease | | | | | | | 🞎 Interstitial disease | | | | | | 🞎 Mixed (airspace and interstitial) disease | | | |
| 🞎 **Pleural Effusion: 🡪** | 🞎 Unilateral | | | | | | | 🞎 Bilateral | | | | | | |  | | |
| 🞎 **Bronchiolitis: 🡪** | 🞎 Complicated | | | | | | | 🞎 Uncomplicated | | | | | | |  | | |
| 🞎 **Other: 🡪** | 🞎 Air leak/Pneumothorax | | | | | | | 🞎 Lymphadenopathy | | | | | 🞎 Chest wall invasion | | | | |
|  | 🞎 Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  | | | | | | |  | | |

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| **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 | | | | | Date started: | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | | | | | Date stopped: | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | |
|  | | | | | 🞎 CPAP | | | | | Date started: | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | | | | | Date stopped: | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | |
|  | | | | | 🞎 BiPAP | | | | | Date started: | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | | | | | Date stopped: | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | |
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| **d. Vasopressor medications (e.g. dopamine, epinephrine)** | | | | | | | | | | | | | | | | | | | | | | | | 🞎 Yes | | | | 🞎 No | | | | 🞎 Unknown | | |
|  | | Date started: | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | Date stopped | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | |
| **e. Dialysis (Acute)** | | | | | | | | | | | | | | | | | | | | | | | | 🞎 Yes | | | | 🞎 No | | | | 🞎 Unknown | | |
|  | | Date started: | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | Date stopped | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | |
| **f. Resuscitation, CPR** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **g. Acute respiratory distress syndrome (ARDS)** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **h. Disseminated intravascular coagulopathy (DIC)** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **i. Hemophagocytic syndrome** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **j. Bronchiolitis** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **k. Pneumonia** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **l. Stroke (Acute)** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **m. Sepsis** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **n. Shock** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| Type: | 🞎hypovolemic | | | 🞎cardiogenic | | | | | | 🞎septic | | | 🞎toxic | | | | | | | | | | | | | | | | | | | | | |
| **o. Acute myocarditis** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **p. Acute myocardial dysfunction** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **q. Acute myocardial infarction** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **r. Seizures** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **s. Reye’s syndrome** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **t. Acute encephalitis / encephalopathy** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **u. Guillain-Barre syndrome** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **v. Rhabdomyolysis** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **w. Acute liver impairment** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **x. Acute renal failure** | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | 🞎 No | | | 🞎 Unknown |
| **y. Other, specify:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | |  | | |  |
| **z. Other, specify:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | 🞎 Yes, date started:\_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | stopped: \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | |  | | |  |
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| **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  Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | 🞎 Fetal loss  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:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **XIII. Additional Comments** |
| **66. Additional Comments:** |
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