

Study ID: _____

**CEIRS Human Influenza Surveillance Study
Form 9A: ED Chart Review - ED Visit**

Review the subject's medical record for the day of enrollment and the subsequent 21 days for visits to the Emergency Department (ED). Each subject will have at least one ED Visit (ED Visit 1), which will be the ED visit during which the subject was enrolled.

Include the date of the ED visit during which the subject was enrolled, how many ED visits did the subject have in the past 21 days? ____ ED visits

Indicate the date of the ED Visit(s):

ED Visit 1 (date of enrollment)

Date: ___/___/____ (mm/dd/yyyy)

ED Visit 2

Date: ___/___/____ (mm/dd/yyyy)

ED Visit 3

Date: ___/___/____ (mm/dd/yyyy)

ED Visit 4

Date: ___/___/____ (mm/dd/yyyy)

ED Visit 5

Date: ___/___/____ (mm/dd/yyyy)

ED Visit 6

Date: ___/___/____ (mm/dd/yyyy)

ED Visit 7

Date: ___/___/____ (mm/dd/yyyy)

ED Visit 8

Date: ___/___/____ (mm/dd/yyyy)

ED Visit 9

Date: ___/___/____ (mm/dd/yyyy)

For each ED visit, complete a separate ED Chart Review Form.

ED Chart Review Form

Instructions: For each ED visit, complete an ED Chart Review Form. Each subject will have at least one ED Visit (ED Visit 1), which will be the ED visit during which the subject was enrolled. Add subsequent forms for additional ED visits within 21 days of enrollment, as necessary, numbering sequentially.

ED Visit # ____ (Begin with visit 1 for the enrollment visit)

1. ED arrival

Arrival Date: ____/____/____ (mm/dd/yyyy)

Arrival Time (24-hour clock): ____ : ____ (hh:mm)

2. ED departure

Departure Date: ____/____/____ (mm/dd/yyyy)

Departure Time (24-hour clock): ____ : ____ (hh:mm)

ED Physical Exam (Initial Exam of ED visit)

3. Initial Vital Signs upon presentation to the ED: (if unknown or not obtained, use "999")

3a. Temperature: _____ ##.#C (range: 35.0 – 42.0; if unknown use "999.9")

3b. Pulse: _____ Beats Per Minute (range: 40 - 200)

3c. Respiratory Rate: _____ Breaths Per Minute (range: 10 - 30)

3d. Systolic Blood Pressure: _____ mm Hg (range: 60 - 200)

3e. Oxygen Saturation: _____ % (range: 70 - 100)

4. Was oxygen supplementation given at this time?

No Yes Unknown

4a. If yes, how much? _____ L/min

4b. What was the route?

Nasal cannula Facemask/non-rebreather BiPAP/CPAP Intubated

5. Pharyngeal Erythema

No Yes Unknown

6. Cervical lymphadenopathy

No Yes Unknown

7. Altered Mental Status or Confusion

No Yes Unknown

ED Laboratory:8. Please insert the following laboratory values (if obtained while in the ED). Use the **first set** of laboratory values obtained in the ED: (if unknown or not obtained, use "999")

8a. pH: _____ (range: 4– 10)

8b. BUN: _____ mg/dL (range: 6 to 20 mg/dL)

8c. Sodium: _____ mEq/L (range: 135 - 145 mEq/L)

8d. Glucose: _____ mg/dL (range: 70 - 180 mg/dL)

8e. Hematocrit: _____ % (range: 20 – 70%)

9. Did the subject receive influenza testing in the ED? No Yes Unknown

(Note: This **does not** including testing done as part of this study protocol)

9a. If yes, how many? _____ influenza tests

For each influenza test, specify the test name, type, result, and the time the test was collected and resulted:

9i. Test 1

Test 1 Name: _____

Test 1 Type: PCR DFA Culture Antigen Other: _____

Test 1 Result: Negative Positive Other

Test 1 Collection Date: ____/____/____ (mm/dd/yyyy)

Test 1 Collection Time (24-hour clock): ___:___ (hh:mm)

Test 1 Result Date: ___/___/___ (mm/dd/yyyy)

Test 1 Result Time (24-hour clock): ___:___ (hh:mm)

Was influenza typing performed? No Yes Unknown

If yes, please specify influenza type: _____

9ii. Test 2

Test 2 Name: _____

Test 2 Type: PCR DFA Culture Antigen Other: _____Test 2 Result: Negative Positive Other

Test 2 Collection Date: ___/___/___ (mm/dd/yyyy)

Test 2 Collection Time (24-hour clock): ___:___ (hh:mm)

Test 2 Result Date: ___/___/___ (mm/dd/yyyy)

Test 2 Result Time (24-hour clock): ___:___ (hh:mm)

Was influenza typing was performed? No Yes Unknown

If yes, please specify influenza type: _____

9iii. Test 3

Test 3 Name: _____

Test 3 Type: PCR DFA Culture Antigen Other: _____Test 3 Result: Negative Positive Other

Test 3 Collection Date: ___/___/___ (mm/dd/yyyy)

Test 3 Collection time (24-hour clock): ___:___ (hh:mm)

Test 3 Result Date: ___/___/___ (mm/dd/yyyy)

Test 3 Result Time (24-hour clock): ___:___ (hh:mm)

Was influenza typing was performed? No Yes Unknown

If yes, please specify influenza type: _____

9iv. Test 4

Test 4 Name: _____

Test 4 Type: PCR DFA Culture Antigen Other: _____Test 4 Result: Negative Positive Other

Test 4 Collection Date: ___/___/___ (mm/dd/yyyy)

Test 4 Collection time (24-hour clock): ___:___ (hh:mm)

Test 4 Result Date: ___/___/___ (mm/dd/yyyy)

Test 4 Result Time (24-hour clock): ___:___ (hh:mm)

Was influenza typing was performed? No Yes Unknown

If yes, please specify influenza type: _____

10. Was the subject diagnosed with any other viruses?

10a. Respiratory Syncytial Virus (RSV) No Yes Unknown10b. Parainfluenza (1,2, or 3) No Yes Unknown10c. Rhinovirus No Yes Unknown10d. Metapneumovirus No Yes Unknown10e. Adenovirus No Yes Unknown**ED Course**11. Did subject receive an influenza antiviral in the ED? No Yes Unknown

11a. If yes, how many antivirals were received? _____ influenza antivirals

11b. For each influenza antiviral received, specify the antiviral name, route of administration, and time influenza antiviral was given.

(Key: PO = by mouth; IN = intranasal; IV = intravenous)

Influenza antiviral 1

Influenza Antiviral 1 Name: _____

Influenza Antiviral 1 Route: PO IN IV

Influenza Antiviral 1 Date administered: ___/___/____ (mm/dd/yyyy)

Influenza Antiviral 1 Time administered (24-hour clock): ___:___ (hh:mm)

Influenza antiviral 2

Influenza Antiviral 2 Name: _____

Influenza Antiviral 2 Route: PO IN IV

Influenza Antiviral 2 Date administered: ___/___/____ (mm/dd/yyyy)

Influenza Antiviral 2 Time administered (24-hour clock): ___:___ (hh:mm)

12. Did the subject receive a prescription for an influenza antiviral upon discharge?

No Yes Unknown N/A, Subject not discharged

12a. If yes, how many? _____ influenza antiviral prescriptions

12b. Please list all influenza antivirals prescribed at discharge (up to two)

Antiviral 1: _____

Antiviral 2: _____

13. Did subject receive an antibiotic in the ED? No Yes Unknown

13a. If yes, how many antibiotics were received? _____ antibiotics

For each antibiotic received, specify the antibiotic name, route of administration, and indication (Key:

PO = by mouth; IM = intramuscular; IV = intravenous)

Antibiotic 1

Antibiotic 1 Name: _____

Antibiotic 1 Route: PO IM IV

Antibiotic 1 Indication: _____

Antibiotic 2

Antibiotic 2 Name: _____

Antibiotic 2 Route: PO IM IV

Antibiotic 2 Indication: _____

Antibiotic 3

Antibiotic 3 Name: _____

Antibiotic 3 Route: PO IM IV

Antibiotic 3 Indication: _____

14. Did the subject receive a prescription for an antibiotic upon discharge?

No Yes Unknown N/A, Subject not discharged

14a. If yes, how many? _____ antibiotics upon discharge

14b. Please list all antibiotics prescribed at discharge and indication.

Discharge Antibiotic 1

Discharge Antibiotic 1 Name: _____

Discharge Antibiotic 1 Indication: _____

Discharge Antibiotic 2

Discharge Antibiotic 2 Name: _____

Discharge Antibiotic 2 Indication: _____

Discharge Antibiotic 3

Discharge Antibiotic 3 Name: _____

Discharge Antibiotic 3 Indication: _____

15. Did the subject have a Chest X-ray or a Chest CT performed in the ED?
 No Yes Unknown

If yes, based on the official read:

15a. Did it show a pulmonary infiltrate? No Yes Unknown

15b. Did it show consolidation? No Yes Unknown

15c. Did it show pleural effusions? No Yes Unknown

15d. Did the radiologist indicate suspicion of pneumonia? No Yes Unknown

16. Was the subject intubated in the ED? No Yes Unknown

17. Did the patient receive BiPAP or CPAP in the ED? No Yes Unknown

18. When the subject left the ED did they require supplemental oxygen?
 No Yes Unknown

18a. If yes, how much? _____ L/min

18b. What was the route?

Nasal cannula Facemask/non-rebreather BiPAP/CPAP Intubated

19. Did the subject die in the ED? No Yes Unknown

19a. If yes, date of death: ___ ___ / ___ ___ / ___ ___ ___ ___ (mm/dd/yyyy)

20. Did the subject have a final diagnosis of

20a. Influenza? No Yes Unknown

20b. Viral Syndrome or Infection? No Yes Unknown

20c. Pneumonia? No Yes Unknown

20d. Myocardial Infarction? No Yes Unknown

20e. Stroke? No Yes Unknown

21. How many final ED diagnoses did the subject have? 1 2 3 more than three
 List the ICD-9 codes for up to the first few final ED Diagnoses, up to the first three:
 (Do not list E or V codes)

21a. Final ED Diagnosis Code 1: _____

21b. Final ED Diagnosis Code 2: _____

21c. Final ED Diagnosis Code 3: _____

22. What was the final subject disposition for this ED visit?
 ADMIT DISCHARGE ELOPE* OTHER

*Elope includes elopement and left without being seen or against medical advice

22a. If other, please specify: _____

24. If this subject had a final disposition of discharge, at any time during this ED visit were they placed in Observation?
 No Yes Unknown

For each additional ED Visit, as applicable, complete another ED Visit Chart Review form