

Study ID: _____

**CEIRS Human Influenza Surveillance Study
Form 10A: Chart Review – Inpatient Hospitalization**

Review the subject's medical record for the day of enrollment and the subsequent 21 days for inpatient hospitalizations.

How many times was the subject hospitalized and admitted in the past 21 days? ____ times
If none, skip to Form 11: 3-week Follow-up Other Doctors Visits

Inpatient Hospitalization Visit 1

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

Inpatient Hospitalization Visit 2

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

Inpatient Hospitalization Visit 3

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

Inpatient Hospitalization Visit 4

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

Inpatient Hospitalization Visit 5

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

Inpatient Hospitalization Visit 6

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

For each inpatient hospitalization, complete a separate Inpatient Hospitalization Chart Review Form.

Inpatient Hospitalization Chart Review Form

Instructions: For each inpatient hospitalization, complete an Inpatient Hospitalization Chart Review Form. Begin with visit one and number sequentially. Do not including any information from ED visits.

Inpatient Hospitalization # _____

1. Date inpatient stay began: ___/___/____ (mm/dd/yyyy)
2. Date inpatient stay ended: ___/___/____ (mm/dd/yyyy)
3. Did the subject receive supplemental oxygen in the hospital?

No Yes Unknown
- 3a. If yes, how much? _____ L/min
- 3b. What was the route?

Nasal cannula Facemask/non-rebreather BiPAP or CPAP Intubated
4. Was subject located in an intensive care unit?

No Yes Unknown

 If yes,
 - 4a. Date ICU stay began: ___/___/____ (mm/dd/yyyy)
 - 4b. Total number of days spent in ICU: _____
5. Did Subject die in the hospital?

No Yes Unknown

 5a. If yes, Date of Death: ___/___/____ (mm/dd/yyyy)
6. Did the subject receive antibiotics in the hospital?

No Yes Unknown

 6a. If yes, how many antibiotics were received? _____ antibiotics
 - 6b. For each antibiotic received, specify the antibiotic name, the date the antibiotic was started, the number of days it was taken for, and the condition for which it was prescribed.
 - 6i. Antibiotic 1

Antibiotic 1 Name: _____

Antibiotic 1 start date: ___/___/____ (mm/dd/yyyy)

Antibiotic 1 number of days taken: _____ days

Antibiotic 1 indication: _____
 - 6ii. Antibiotic 2

Antibiotic 2 Name: _____

Antibiotic 2 start date: ___/___/____ (mm/dd/yyyy)

Antibiotic 2 number of days taken: _____ days

Antibiotic 2 indication: _____
 - 6iii. Antibiotic 3

Antibiotic 3 Name: _____

Antibiotic 3 start date: ___/___/____ (mm/dd/yyyy)

Antibiotic 3 number of days taken: _____ days

Antibiotic 3 indication: _____
 - 6iv. Antibiotic 4

Antibiotic 4 Name: _____

Antibiotic 4 start date: ___/___/____ (mm/dd/yyyy)

Antibiotic 4 number of days taken: _____ days

Antibiotic 4 indication: _____

7. Did subject receive influenza testing in the hospital? No Yes Unknown

7a. If yes, how many? _____ influenza tests

7b. For each influenza test, specify the following:

7i. 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 was performed? No Yes Unknown

If yes, please list influenza type: _____

7ii. 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 list influenza type: _____

7iii. 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 list influenza type: _____

7iv. 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 list influenza type: _____

8. Did subject receive influenza antiviral in the hospital? No Yes Unknown
 8a. If yes, how many antivirals were received? _____ influenza antivirals
 8b. For each influenza antivirals received, specify the antiviral name, route of administration, and date the influenza antiviral was given.

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

8i. 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)

8ii. 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)

9. Did the subject have a final diagnosis of

- 9a. Influenza? No Yes Unknown
 9b. Viral Syndrome or Infection? No Yes Unknown
 9c. Pneumonia? No Yes Unknown
 9d. Myocardial Infarction? No Yes Unknown
 9e. Stroke? No Yes Unknown

10. How many final inpatient hospitalization diagnoses did the subject have?

- 1 2 3 more than three

List the ICD-9 codes for up to the first few final inpatient hospitalization diagnoses, up to the first three:

(Do not use any E or V codes)

- 10a. Final Inpatient Diagnosis Code 1: _____
 10b. Final Inpatient Diagnosis Code 2: _____
 10c. Final Inpatient Diagnosis Code 3: _____