Form Approved
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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

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	Unknow
9b. Viral Syndrome or Infection?	No	Yes	Unknow
9c. Pneumonia?	No	Yes	Unknow
9d. Myocardial Infarction?	No	Yes	Unknow
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: ____________________