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 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** |
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| **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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| 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 |
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| **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 | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |
|  | 🞎 PO 🞎 IV 🞎 IM | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |
| **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: |
|  |
|  |
|  |
|  |
| 🞎 **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: |
|  |
|  |
|  |
|  |
| 🞎 **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: | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |
| **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/deliveryDescribe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 Fetal lossDate \_\_\_\_/\_\_\_\_/\_\_\_\_\_ |
| **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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