U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
AND PREVENTION
ATLANTA, GA 30333

# 2015-16 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form

Form Approved
OMB No. 0920-0978

**Case ID:** _____ _____ 1 5 1 6 _____ _____ _____ _____

## A. Patient Data – THIS INFORMATION IS NOT SENT TO CDC

Last Name: _____ First Name: _____ Chart Number: _____

Address: _____ Census Tract: _____ Address Type: _____
(Number, Street, Apt. No.)

_____ _____ _____ Emergency Contact 1: _____
(City) (State) (Zip Code)

Phone No.1: _____ Phone No.2: _____ Emergency Contact Phone: _____

PCP Name 1: _____ PCP Phone 1: _____ PCP Fax 1: _____

PCP Name 2: _____ PCP Phone 2: _____ PCP Fax 2: _____

Site Use 1: _____ Site Use 2: _____ Site Use 3: _____

## B. Reporter Information – THIS INFORMATION IS NOT SENT TO CDC

1. Reporter Name: _____ 2. Date Reported: _____ /_____ /_____

## C. Enrollment Information

**1. Case Classification:** ☐ Prospective Surveillance ☐ Discharge Audit

**2. Admission Type:** ☐ Hospitalization ☐ Observation Only

**3. County:**

**4. State:**

**5. Case Type:** ☐ Pediatric ☐ Adult

**6. Date of Birth:** _____ /_____ /_____

**7. Age:** _____ ☐ Years ☐ Days (if < 1 month) ☐ Months (if < 1 yr)

**8. Sex:** ☐ Female ☐ Male

**9. Race:** ☐ White ☐ Black or African American ☐ Asian/Pacific Islander ☐ American Indian or Alaska Native ☐ Multiracial ☐ Not specified

**10. Ethnicity:** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Not Specified

**11. Hospital ID Where Patient Treated:** _____

**11a. Admission Date:** _____ /_____ /_____

**11b. Discharge Date:** _____ /_____ /_____

**12. Was patient transferred from another hospital?** ☐ Yes ☐ No ☐ Unknown

**12a. Transfer Hospital ID:** _____

**12b. Transfer Hospital Admission Date:** _____ /_____ /_____

**12c. Transfer Date:** _____ /_____ /_____

**13. Where did patient reside at the time of hospitalization?** (Indicate TYPE of residence.)

☐ Private residence ☐ Homeless/Shelter ☐ Nursing home ☐ Alcohol/Drug Abuse Treatment ☐ Hospitalized at birth ☐ Rehabilitation facility ☐ Jail/Prison ☐ Hospice ☐ Assisted living/Residential care ☐ LTACH/Transitional Care (TCU) ☐ Group home/Retirement home ☐ Mental Hospital ☐ Unknown ☐ Other, specify: _____

**13a. If resident of a facility, indicate NAME of facility:** _____

## D. Influenza Testing Results

**1. Test 1:** ☐ Rapid ☐ Molecular Assay ☐ Viral Culture ☐ Serology ☐ Fluorescent Antibody ☐ Method Unknown/Note Only

**1a. Result:** ☐ Flu A (no subtype) ☐ 2009 H1N1 ☐ H1, Unspecified ☐ H3 ☐ Flu A, Unsubtypable ☐ Flu B (no genotype) ☐ Flu B, Victoria ☐ Flu B, Yamagata ☐ Flu A & B ☐ Flu A/B (Not Distinguished) ☐ Unknown Type ☐ Negative ☐ Other, specify: _____

**1b. Specimen collection date:** _____ /_____ /_____ **1c. Testing facility ID:** _____ **1d. Specimen ID:** _____

**2. Test 2:** ☐ Rapid ☐ Molecular Assay ☐ Viral Culture ☐ Serology ☐ Fluorescent Antibody ☐ Method Unknown/Note Only

**2a. Result:** ☐ Flu A (no subtype) ☐ 2009 H1N1 ☐ H1, Unspecified ☐ H3 ☐ Flu A, Unsubtypable ☐ Flu B (no genotype) ☐ Flu B, Victoria ☐ Flu B, Yamagata ☐ Flu A & B ☐ Flu A/B (Not Distinguished) ☐ Unknown Type ☐ Negative ☐ Other, specify: _____

**2b. Specimen collection date:** _____ /_____ /_____ **2c. Testing facility ID:** _____ **2d. Specimen ID:** _____

**3. Test 3:** ☐ Rapid ☐ Molecular Assay ☐ Viral Culture ☐ Serology ☐ Fluorescent Antibody ☐ Method Unknown/Note Only

**3a. Result:** ☐ Flu A (no subtype) ☐ 2009 H1N1 ☐ H1, Unspecified ☐ H3 ☐ Flu A, Unsubtypable ☐ Flu B (no genotype) ☐ Flu B, Victoria ☐ Flu B, Yamagata ☐ Flu A & B ☐ Flu A/B (Not Distinguished) ☐ Unknown Type ☐ Negative ☐ Other, specify: _____

**3b. Specimen collection date:** _____ /_____ /_____ **3c. Testing facility ID:** _____ **3d. Specimen ID:** _____

**4. Test 4:** ☐ Rapid ☐ Molecular Assay ☐ Viral Culture ☐ Serology ☐ Fluorescent Antibody ☐ Method Unknown/Note Only

**4a. Result:** ☐ Flu A (no subtype) ☐ 2009 H1N1 ☐ H1, Unspecified ☐ H3 ☐ Flu A, Unsubtypable ☐ Flu B (no genotype) ☐ Flu B, Victoria ☐ Flu B, Yamagata ☐ Flu A & B ☐ Flu A/B (Not Distinguished) ☐ Unknown Type ☐ Negative ☐ Other, specify: _____

**4b. Specimen collection date:** _____ /_____ /_____ **4c. Testing facility ID:** _____ **4d. Specimen ID:** _____

**2015-16 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form**

**Case ID:** _____ _____ 1 5 1 6 _____ _____ _____ _____

## E. Admission and Patient History

**1. Was patient discharged from any hospital within one week prior to the current admission date?** ☐ Yes ☐ No ☐ Unknown

**2. Acute signs/symptoms at admission** ***[within 2 weeks prior to positive flu test]*****:** (*Write* **Y** *or* **N/Unk** *next to signs/symptoms*)

| | | | | |
|---|---|---|---|---|
| _____ Altered mental status/confusion | _____ Cough* | _____ Headache | _____ Seizures | _____ Wheezing* |
| _____ Chest pain | _____ Diarrhea | _____ Myalgia/muscle aches | _____ Shortness of breath/resp distress* | _____ Other, non-respiratory |
| _____ Congested/runny nose* | _____ Fatigue/weakness | _____ Nausea/vomiting | _____ Sore throat* | |
| _____ Conjunctivitis/pink eye | _____ Fever/chills | _____ Rash | _____ URI/ILI* | |

**3. Date of onset of acute respiratory symptoms** ***[within 2 weeks prior to positive flu test]*****:** _____ /_____ /_____ ☐ Unknown

**4. Date of onset of acute condition resulting in current hospitalization:** _____ /_____ /_____ ☐ Unknown

| 5. BMI: _____ | 6. Height: _____ | 7. Weight: _____ | 8. Smoker: | 9. Alcohol abuse: |
|---|---|---|---|---|
| ☐ Unknown | ☐ In ☐ Cm ☐ Unknown | ☐ Lbs ☐ Kg ☐ Unknown | ☐ Current ☐ Former ☐ No/Unknown | ☐ Current ☐ Former ☐ No/Unknown |

**10. Did patient have any of the following pre-existing medical conditions? Check all that apply.** ☐ Yes ☐ No ☐ Unknown

**10a. Asthma/Reactive Airway Disease?** ☐ Yes ☐ No/Unknown

**10b. Chronic Lung Disease?** ☐ Yes ☐ No/Unknown
- ☐ Cystic fibrosis
- ☐ Emphysema/COPD
- ☐ Other, specify: _____

**10c. Chronic Metabolic Disease** ☐ Yes ☐ No/Unknown
- ☐ Diabetes Mellitus
- ☐ Thyroid dysfunction
- ☐ Other, specify: _____

**10d. Blood disorders/Hemoglobinopathy** ☐ Yes ☐ No/Unknown
- ☐ Sickle cell disease
- ☐ Splenectomy/Asplenia
- ☐ Thrombocytopenia
- ☐ Other, specify: _____

**10e. Cardiovascular Disease** ☐ Yes ☐ No/Unknown
- ☐ Atherosclerotic cardiovascular disease (ASCVD)
- ☐ Atrial Fibrillation
- ☐ Cerebral vascular incident/Stroke
- ☐ Congenital heart disease
- ☐ Coronary artery disease (CAD)
- ☐ Heart failure/CHF
- ☐ Other, specify: _____

**10f. Neuromuscular disorder** ☐ Yes ☐ No/Unknown
- ☐ Duchenne muscular dystrophy
- ☐ Muscular dystrophy
- ☐ Multiple sclerosis
- ☐ Mitochondrial disorder
- ☐ Myasthenia gravis
- ☐ Other, specify: _____

**10g. Neurologic disorder** ☐ Yes ☐ No/Unknown
- ☐ Cerebral palsy
- ☐ Cognitive dysfunction
- ☐ Dementia
- ☐ Developmental delay
- ☐ Down syndrome
- ☐ Plegias/Paralysis
- ☐ Seizure/Seizure disorder
- ☐ Other, specify: _____

**10h History of Guillain-Barré Syndrome** ☐ Yes ☐ No/Unknown

**10i. Immunocompromised Condition** ☐ Yes ☐ No/Unknown
- ☐ AIDS or CD4 count < 200
- ☐ Cancer: current/in treatment or diagnosed in last 12 months
- ☐ Complement deficiency
- ☐ HIV Infection
- ☐ Immunoglobulin deficiency
- ☐ Immunosuppressive therapy
- ☐ Organ transplant
- ☐ Stem cell transplant (e.g., bone marrow transplant)
- ☐ Steroid therapy (taken within 2 weeks of admission)
- ☐ Other, specify: _____

**10j. Renal Disease** ☐ Yes ☐ No/Unknown
- ☐ Chronic kidney disease/chronic renal insufficiency
- ☐ End stage renal disease/Dialysis
- ☐ Glomerulonephritis
- ☐ Nephrotic syndrome
- ☐ Other, specify: _____

**10k. Other** ☐ Yes ☐ No/Unknown
- ☐ Intravenous drug use
- ☐ Liver disease (e.g., cirrhosis, chronic hepatitis, hepatitis C)
- ☐ Systemic lupus erythematosus/SLE/Lupus
- ☐ Morbidly obese (ADULTS ONLY)
- ☐ Obese
- ☐ Pregnant
  - ☐ If pregnant, specify gestational age in weeks: _____
  - ☐ Unknown gestational age
- ☐ Post-partum (two weeks or less)
- ☐ Other, specify: _____

### 10l. PEDIATRIC CASES ONLY

**Abnormality of upper airway** ☐ Yes ☐ No/Unknown

**History of febrile seizures** ☐ Yes ☐ No/Unknown

**Long-term aspirin therapy** ☐ Yes ☐ No/Unknown

**Premature** ☐ Yes ☐ No/Unknown

(gestation age < 37 weeks at birth for patients < 2yrs)

If yes, specify gestational age at birth in weeks: _____

☐ Unknown gestational age at birth

**These are considered acute respiratory symptoms*

## F. Intensive Care Unit and Interventions

**1. Was the patient admitted to an intensive care unit (ICU)?** ☐ Yes ☐ No ☐ Unknown

**1a. Number of ICU admissions:** _____ ☐ Unknown

**1b. Date of first ICU Admission:** _____ /_____ /_____ ☐ Unknown

**1c. Date of first ICU Discharge:** _____ /_____ /_____ ☐ Unknown

**2. Did patient receive mechanical ventilation?** ☐ Yes ☐ No ☐ Unknown

**3. Did patient receive extracorporeal membrane oxygenation (ECMO or 'on bypass')?** ☐ Yes ☐ No ☐ Unknown

## G. Bacterial Pathogens – *Sterile or respiratory site only*

**1. Were any bacterial culture tests performed with a collection date within three days of admission?** ☐ Yes ☐ No ☐ Unknown

**2. If yes, was there a positive culture for a bacterial pathogen?** ☐ Yes ☐ No ☐ Unknown

**3a. If yes, specify Pathogen 1:** _____

**3b. Date of culture:** _____ /_____ /_____

**3c. Site where pathogen identified:**
☐ Blood ☐ Cerebrospinal fluid (CSF)
☐ Bronchoalveolar lavage (BAL) ☐ Sputum
☐ Pleural fluid ☐ Endotracheal aspirate
☐ Other, specify: _____

**3d. If Staphylococcus aureus, specify:**
☐ Methicillin resistant (MRSA) ☐ Methicillin sensitive (MSSA) ☐ Sensitivity unknown

**3e. If Haemophilus influenzae, specify if type B:**
☐ Yes ☐ No ☐ Unknown

**3f. If Neisseria meningitidis, specify serogroup:**
☐ B ☐ C ☐ Y
☐ Other, specify: _____ ☐ Unknown

**4a. If yes, specify Pathogen 2:** _____

**4b. Date of culture:** _____ /_____ /_____

**4c. Site where pathogen identified:**
☐ Blood ☐ Cerebrospinal fluid (CSF)
☐ Bronchoalveolar lavage (BAL) ☐ Sputum
☐ Pleural fluid ☐ Endotracheal aspirate
☐ Other, specify: _____

**4d. If Staphylococcus aureus, specify:**
☐ Methicillin resistant (MRSA) ☐ Methicillin sensitive (MSSA) ☐ Sensitivity unknown

**4e. If Haemophilus influenzae, specify if type B:**
☐ Yes ☐ No ☐ Unknown

**4f. If Neisseria meningitidis, specify serogroup:**
☐ B ☐ C ☐ Y
☐ Other, specify: _____ ☐ Unknown

## H. Viral Pathogens

**1. Was patient tested for any of the following viral respiratory pathogens within 3 days of admission?** ☐ Yes ☐ No ☐ Unknown

| | | | | |
|---|---|---|---|---|
| **1a. Respiratory syncytial virus/RSV** | ☐ Yes, positive | ☐ Yes, negative | ☐ Not tested/Unknown | **Date:** _____ /_____ /_____ |
| **1b. Adenovirus** | ☐ Yes, positive | ☐ Yes, negative | ☐ Not tested/Unknown | **Date:** _____ /_____ /_____ |
| **1c. Parainfluenza 1** | ☐ Yes, positive | ☐ Yes, negative | ☐ Not tested/Unknown | **Date:** _____ /_____ /_____ |
| **1d. Parainfluenza 2** | ☐ Yes, positive | ☐ Yes, negative | ☐ Not tested/Unknown | **Date:** _____ /_____ /_____ |
| **1e. Parainfluenza 3** | ☐ Yes, positive | ☐ Yes, negative | ☐ Not tested/Unknown | **Date:** _____ /_____ /_____ |
| **1f. Parainfluenza 4** | ☐ Yes, positive | ☐ Yes, negative | ☐ Not tested/Unknown | **Date:** _____ /_____ /_____ |
| **1g. Human metapneumovirus** | ☐ Yes, positive | ☐ Yes, negative | ☐ Not tested/Unknown | **Date:** _____ /_____ /_____ |
| **1h. Rhinovirus/Enterovirus** | ☐ Yes, positive | ☐ Yes, negative | ☐ Not tested/Unknown | **Date:** _____ /_____ /_____ |
| **1i. Coronavirus (type):** _____ | ☐ Yes, positive | ☐ Yes, negative | ☐ Not tested/Unknown | **Date:** _____ /_____ /_____ |

## I. Influenza Treatment

**1. Did patient receive antiviral medication treatment for influenza during the course of this illness?** ☐ Yes ☐ No ☐ Unknown

**2a. Treatment 1:** ☐ Oseltamivir (Tamiflu) ☐ Zanamivir (Relenza) ☐ Other, specify: _____
☐ Amantadine (Symmetrel) ☐ Rimantadine (Flumadine) ☐ Unknown

**2b. Method of Administration:** ☐ Oral ☐ Intravenous (IV) ☐ Inhaled ☐ Unknown

**2c. Start Date:** _____ /_____ /_____ ☐ Start Date Unknown
**2d. End Date:** _____ /_____ /_____ ☐ End Date Unknown
**2e. Dose:** _____ ☐ Dose Unknown
**2f. Frequency:** _____ ☐ Frequency Unknown

**3a. Treatment 2:** ☐ Oseltamivir (Tamiflu) ☐ Zanamivir (Relenza) ☐ Other, specify: _____
☐ Amantadine (Symmetrel) ☐ Rimantadine (Flumadine) ☐ Unknown

**3b. Method of Administration:** ☐ Oral ☐ Intravenous (IV) ☐ Inhaled ☐ Unknown

**3c. Start Date:** _____ /_____ /_____ ☐ Start Date Unknown
**3d. End Date:** _____ /_____ /_____ ☐ End Date Unknown
**3e. Dose:** _____ ☐ Dose Unknown
**3f. Frequency:** _____ ☐ Frequency Unknown

**4a. Treatment 3:** ☐ Oseltamivir (Tamiflu) ☐ Zanamivir (Relenza) ☐ Other, specify: _____
☐ Amantadine (Symmetrel) ☐ Rimantadine (Flumadine) ☐ Unknown

**4b. Method of Administration:** ☐ Oral ☐ Intravenous (IV) ☐ Inhaled ☐ Unknown

**4c. Start Date:** _____ /_____ /_____ ☐ Start Date Unknown
**4d. End Date:** _____ /_____ /_____ ☐ End Date Unknown
**4e. Dose:** _____ ☐ Dose Unknown
**4f. Frequency:** _____ ☐ Frequency Unknown

**5a. Treatment 4:** ☐ Oseltamivir (Tamiflu) ☐ Zanamivir (Relenza) ☐ Other, specify: _____
☐ Amantadine (Symmetrel) ☐ Rimantadine (Flumadine) ☐ Unknown

**5b. Method of Administration:** ☐ Oral ☐ Intravenous (IV) ☐ Inhaled ☐ Unknown

**5c. Start Date:** _____ /_____ /_____ ☐ Start Date Unknown
**5d. End Date:** _____ /_____ /_____ ☐ End Date Unknown
**5e. Dose:** _____ ☐ Dose Unknown
**5f. Frequency:** _____ ☐ Frequency Unknown

**6. Additional Treatment Comments:**

## J. Chest Radiograph – *Based on radiology report only*

**1. Was a chest x-ray taken *within 3 days* of admission?** ☐ Yes ☐ No ☐ Unknown

**2. Were any of these chest x-rays abnormal?** ☐ Yes ☐ No ☐ Unknown

**2a. Date of first abnormal chest x-ray:** _____ /_____ /_____

**2b. For first abnormal chest x-ray, please check all that apply:**

☐ Report not available
☐ Air space density/opacity
☐ Bronchopneumonia/pneumonia
☐ Cannot rule out pneumonia
☐ Consolidation
☐ Atelectasis
☐ Cavitation
☐ ARDS (acute respiratory distress syndrome)
☐ Interstitial infiltrate
☐ Pleural effusion/empyema
☐ Lobar infiltrate
☐ Other

## K. Discharge Summary

**1. Did the patient have any of the following diagnoses at discharge? (check all that apply)**

| | | | | | |
|---|---|---|---|---|---|
| Pneumonia | ☐ Yes ☐ No ☐ Unknown | | Stroke (CVI) | ☐ Yes ☐ No ☐ Unknown | |
| Guillain-Barré syndrome | ☐ Yes ☐ No ☐ Unknown | | Acute myocarditis | ☐ Yes ☐ No ☐ Unknown | |
| Acute encephalopathy/ encephalitis | ☐ Yes ☐ No ☐ Unknown | | Acute respiratory distress syndrome (ARDS) | ☐ Yes ☐ No ☐ Unknown | |
| Seizures | ☐ Yes ☐ No ☐ Unknown | | Bronchiolitis | ☐ Yes ☐ No ☐ Unknown | |
| Reye's syndrome | ☐ Yes ☐ No ☐ Unknown | | Hemophagocytic syndrome | ☐ Yes ☐ No ☐ Unknown | |

**2. What was the outcome of the patient?**

☐ Alive
☐ Deceased
☐ Unknown

**2a. If discharged alive, please indicate to where:**

☐ Private residence
☐ Homeless/Shelter
☐ Nursing home
☐ Alcohol/Drug Abuse Treatment
☐ Home with services
☐ Rehabilitation Facility
☐ Jail/Prison
☐ Hospice
☐ Assisted living/Residential care
☐ LTACH/Transitional Care (TCU)
☐ Group home/Retirement home
☐ Mental Hospital
☐ Unknown
☐ Other, specify: _____

**3. If patient was pregnant on admission, indicate pregnancy status at discharge:** ☐ Still pregnant ☐ No longer pregnant ☐ Unknown

**3a. If patient was pregnant on admission but no longer pregnant at discharge, indicate pregnancy outcome at discharge:**

☐ Miscarriage ☐ Ill newborn ☐ Newborn died ☐ Healthy newborn ☐ Abortion ☐ Unknown

**4. Additional notes regarding discharge:**

## L. ICD-9 or ICD-10 Discharge Diagnoses – *To be recorded in order of appearance*

**Version:**
☐ ICD-9
☐ ICD-10

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

## M. Vaccination History

**Specify vaccination status and date(s) by source:**

**1. Medical Chart:** ☐ Yes, full date known ☐ Yes, specific date unknown ☐ No ☐ Unknown ☐ Not Checked

**1a. If yes, specify dosage date information:** 1) _____ /_____ /_____ ☐ Date Unknown 2) (Pediatrics Only) _____ /_____ /_____ ☐ Date Unknown

**1b. If patient < 9 yrs, specify vaccine type:** ☐ Injected Vaccine ☐ Nasal Spray/FluMist ☐ Combination of both ☐ Unknown type

**2.Vaccine Registry:** ☐ Yes, full date known ☐ Yes, specific date unknown ☐ No ☐ Unknown ☐ Not Checked

**2a. If yes, specify dosage date information:** 1) _____ /_____ /_____ ☐ Date Unknown 2) (Pediatrics Only) _____ /_____ /_____ ☐ Date Unknown

**2b. If patient < 9 yrs, specify vaccine type:** ☐ Injected Vaccine ☐ Nasal Spray/FluMist ☐ Combination of both ☐ Unknown type

**3. Primary Care Provider / Long-term Care Facility:** ☐ Yes, full date known ☐ Yes, specific date unknown ☐ No ☐ Unknown ☐ Not Checked

**3a. If yes, specify dosage date information:** 1) _____ /_____ /_____ ☐ Date Unknown 2) (Pediatrics Only) _____ /_____ /_____ ☐ Date Unknown

**3b. If patient < 9 yrs, specify vaccine type:** ☐ Injected Vaccine ☐ Nasal Spray/FluMist ☐ Combination of both ☐ Unknown type

**4. Interview:** ☐ Patient ☐ Proxy ☐ Yes, full date known ☐ Yes, specific date unknown ☐ No ☐ Unknown ☐ Not Checked

**4a. If yes, specify dosage date information:** 1) _____ /_____ /_____ ☐ Date Unknown 2) (Pediatrics Only) _____ /_____ /_____ ☐ Date Unknown

**4b. If patient < 9 yrs, specify vaccine type:** ☐ Injected Vaccine ☐ Nasal Spray/FluMist ☐ Combination of both ☐ Unknown type

**5. If patient < 9 yrs, did patient receive any seasonal influenza vaccine in previous seasons?** ☐ Yes ☐ No ☐ Unknown

## N. Miscellaneous

**1. Additional Comments:**