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:** _____

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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: