

Antiviral-Resistant Influenza Infection Case Report Form

Form Approved
OMB No. 0920-0004

FAX COMPLETED FORM TO: 404-639-3866

CDC ID (CDC use only): _____

I. Specimen Information					
State Lab Specimen ID _____ Specimen Collection State _____ Patient County of residence _____ Patient State of residence _____ Oseltamivir resistance <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Zanamivir resistance <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Reason for Antiviral Resistance Test: <input type="checkbox"/> Requested for Clinical Indication <input type="checkbox"/> Surveillance <input type="checkbox"/> Other _____		Influenza type/subtype: <input type="checkbox"/> Influenza A <input type="checkbox"/> H1N1 <input type="checkbox"/> H3N2 <input type="checkbox"/> Influenza B <input type="checkbox"/> Unknown		
II. Basic Information If information is from patient interview please READ: <i>I'm going to ask you for some information about yourself (your child) and your (the child's) illness. To help you remember, I am going to tell you the date that your nose/ throat swab was taken to test for flu (use specimen collection date in section I). Please feel free to look at a calendar to help you remember dates. I can wait until you find one.</i>					
Age: __ __ <input type="checkbox"/> yrs <input type="checkbox"/> months Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	Race: <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	Illness History: Date of illness onset: ___/___/_____ Hospitalized for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Patient Outcome: <input type="checkbox"/> At Home <input type="checkbox"/> At Extended Care Facility <input type="checkbox"/> Currently Hospitalized <input type="checkbox"/> Dead (Was it influenza-related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown) <input type="checkbox"/> Unknown		
III. Pre-existing Medical Conditions					
Did a doctor ever tell you that you (your child) had any of the following conditions? (Check all that apply)					
<input type="checkbox"/> No underlying conditions <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Chronic kidney disease <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic lung disease (non-asthma), specify _____ <input type="checkbox"/> Neurologic/neuromuscular disease				<input type="checkbox"/> Immunosuppressive condition (complete section below) <input type="checkbox"/> Chronic Heart Disease, specify: _____ <input type="checkbox"/> Chronic Liver Disease, specify: _____ <input type="checkbox"/> Morbid obesity: Height _____ Weight _____ <input type="checkbox"/> Other Condition, specify: _____ If female aged ≥16 years, were you pregnant at time of specimen collection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Trimester _____	
Immunosuppression Details (check all that apply)					
	<input type="checkbox"/> Solid Tumor Malignancy:	<input type="checkbox"/> Hematologic Malignancy:	<input type="checkbox"/> Receipt of Stem Cell Transplant	<input type="checkbox"/> Receipt of Solid Organ Transplant	<input type="checkbox"/> Autoimmune Disorder
Specify type(s)					
<input type="checkbox"/> Other condition (Lupus, Rheumatoid Arthritis, Crohns, etc) Specify Type (s): _____					<input type="checkbox"/> HIV/AIDS
IV. Hospitalized Patient Information (skip to section V if patients is not hospitalized)					
Date of hospital admission: ___/___/_____ Date of hospital discharge: ___/___/_____ Reason for Hospital Admission: <input type="checkbox"/> Respiratory Illness <input type="checkbox"/> Other, specify: _____			Where was the patient discharged to? <input type="checkbox"/> Other hospital <input type="checkbox"/> Home <input type="checkbox"/> Hospice <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Long term care facility <input type="checkbox"/> Other		
During hospitalization, was patient in Intensive Care Unit? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0004).

V. Influenza Antiviral Medication History

Received influenza antiviral medications including oseltamivir (Tamiflu®) or zanamivir (Relenza®)?

Yes No (skip to section VI) Unknown (skip to section VI)

If yes, Please check all below that apply:

Oseltamivir (Tamiflu)

Dose: 75mg Other _____ Frequency: QD BID Other _____ Indication: Treatment Prevention
Location: Outpatient Inpatient Start Date: ___/___/_____ End Date: ___/___/_____

Zanamivir (Relenza)

Dose: 10mg Other _____ Route: Inhaled IV (experimental) Frequency: QD BID Other _____
Indication: Treatment Prevention Location: Outpatient Inpatient
Start Date: ___/___/_____ End Date: ___/___/_____

Additional/other Agent

Name: _____
Dose: _____ Route: Oral IV Inhaled Frequency: BID Other _____
Indication: Treatment Prevention Location: Outpatient Inpatient
Start Date: ___/___/_____ End Date: ___/___/_____

Patient finished all of the pills (or suspension)? Yes No Unknown

Information on antiviral treatment is from (check all that apply)

inpatient medical record outpatient medical record dispensing pharmacy self-report

Comments about antiviral therapy: (e.g. other courses of antiviral treatment, reasons for poor compliance, etc.)

VI. Influenza Vaccine History

Did you (your child) receive the influenza vaccine this year? Yes No Unknown

VII. Clinical Illness [Read to patient: *I am going to ask you some questions about your (your child's) illness. Please feel free to look at the calendar to help you remember.*]

- 1. Did you (your child) have a fever or feel feverish when you (he/she) had flu? Yes No (skip to Q2) DK (skip to Q2)
1a. How many days did you (your child) have fever? _____ day(s)
1b. Did you take your (your child's) temperature? Yes No (skip to Q2) DK (skip to Q2)
1c. What was the highest temperature that you recorded? _____
- 6. On what date did you first seek medical care for the flu illness? ___/___/_____

VIII. Transmission History [Read to patient: *I'm going to ask some questions about others in your home who may have been ill and travel.*]

- 1. At the time you (your child) became ill, where did you reside? Single Family House (1 housing unit in building)
 University Dorm or boarding school Multi-Family Housing (> 1 unit in building)
 Other, specify: _____ Facility (hospital, long term care, nursing home, jail, etc)
- 2. During the week before illness, did anyone else in the household have flu or a respiratory illness? Yes No Unknown
If yes, how many? _____
If Yes, Did anyone else other than you in the household get a diagnosis of flu? Yes No Unknown
If yes, how many? _____
- 3. During the week before illness, did anyone else in the household receive any antiviral medications? Yes (for treatment for prevention)
 No Unknown
If yes, What was the name of the antiviral agent? Tamiflu Relenza Unknown Other specify _____
- 4. Did you travel outside of your typical residence area during the 7 days prior to illness? Yes No Unknown
If yes, Where did you travel to? Country _____ state _____ city/town _____
Dates of travel? ___/___/_____ to ___/___/_____

If the patient is a child, university student or living in a facility (e.g. LTCF), ask the following questions, if not, skip to the next section.

- 5. Were others at your (your child's) school/residency also sick at the same time as your (the child's) flu illness?
 Yes No DK **If yes**, where do you (your child) go to school/ reside? _____

IX. Additional Comments

Sender Information

First Name:	Last Name:	Date of Survey Completion: __/__/____
Institution Name:	Email Address:	Telephone Number: