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 ☐ Yes ☐ No ☐ Unk
Zanamivir resistance ☐ Yes ☐ No ☐ Unk

Reason for Antiviral Resistance Test:
☐ Requested for Clinical Indication
☐ Surveillance
☐ Other _____

Date of Specimen Collection:
__ __/ __ __/ __ __ __ __

Influenza type/subtype:
☐ Influenza A
☐ H1N1
☐ H3N2
☐ Influenza B
☐ Unknown

II. Basic Information

If information is from patient interview please READ:: *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.*

Age: __ __ ☐ yrs ☐ months

Sex: ☐ Male ☐ Female

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Race:
☐ American Indian/ Alaska Native
☐ Asian or Pacific Islander
☐ Black or African American
☐ White
☐ Other _____
☐ Unknown

Illness History:
Date of illness onset:
__ __/ __ __/ __ __ __ __
Hospitalized for illness?
☐Yes
☐No
☐Unknown

Patient Outcome:
☐ At Home
☐ At Extended Care Facility
☐ Currently Hospitalized
☐ Dead (Was it influenza-related? ☐Yes ☐ No ☐ Unknown)
☐ 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)

☐ No underlying conditions
☐ Diabetes Mellitus
☐ Chronic kidney disease
☐ Asthma
☐ Chronic lung disease (non-asthma), specify_____
☐ Neurologic/neuromuscular disease
☐ Immunosuppressive condition **(complete section below)**
☐ Chronic Heart Disease, specify: _____
☐ Chronic Liver Disease, specify: _____
☐ Morbid obesity: Height _____ Weight _____
☐ Other Condition, specify: _____

If female aged ≥16 years, were you pregnant at time of specimen collection: ☐ Yes ☐ No ☐ Unknown Trimester _____

Immunosuppression Details (check all that apply)

	☐ Solid Tumor Malignancy:	☐ Hematologic Malignancy:	☐ Receipt of Stem Cell Transplant	☐ Receipt of Solid Organ Transplant	☐ Autoimmune Disorder
Specify type(s)					

☐ Other condition (Lupus, Rheumatoid Arthritis, Crohns, etc) Specify Type (s): ☐ HIV/AIDS

IV. Hospitalized Patient Information (skip to section V if patients is not hospitalized)

Date of hospital admission: __ __/ __ __/ __ __ __ __
Date of hospital discharge: __ __/ __ __/ __ __ __ __

Where was the patient discharged to?
☐ Other hospital ☐ Home ☐ Hospice ☐ Rehabilitation facility
☐ Long term care facility ☐ Other

Reason for Hospital Admission: ☐ Respiratory Illness ☐ Other, specify:

During hospitalization, was patient in Intensive Care Unit? ☐ Yes ☐ No ☐ Unknown

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: