Form Approved
OMB No. 0920-0987
08/31/2016

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Case ID:__ __ 1 4 1 5 __ __

2014-15 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form

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

Last Name:	**First Name:**	**Phone Number 1:**	**Phone Number 2:**
Street Address:		**City:**	**Zip:**
Chart Number:		**Census Tract:**	**Address Type:**
Emergency Contact 1:		**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: ☐ Male ☐ Female

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 ☐ Alcohol/Drug Abuse Treatment ☐ Assisted living/Residential care ☐ Group home/Retirement home
☐ Homeless/Shelter ☐ Hospitalized at birth ☐ Jail/Prison ☐ LTACH/Transitional Care (TCU) ☐ Mental Hospital
☐ Nursing home ☐ Rehabilitation facility ☐ Hospice ☐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) ☐ Flu B (no genotype) ☐ Flu A & B ☐ Flu A/B (Not Distinguished)
☐ 2009 H1N1 ☐ H1, Unspecified ☐ H3 ☐ Flu A, Unsubtypable ☐ Flu B, Yamagata
☐ Flu B, Victoria ☐ Negative ☐ Unknown Type ☐ 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) ☐ Flu B (no genotype) ☐ Flu A & B ☐ Flu A/B (Not Distinguished)
☐ 2009 H1N1 ☐ H1, Unspecified ☐ H3 ☐ Flu A, Unsubtypable ☐ Flu B, Yamagata
☐ Flu B, Victoria ☐ Negative ☐ Unknown Type ☐ 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) ☐ Flu B (no genotype) ☐ Flu A & B ☐ Flu A/B (Not Distinguished)
☐ 2009 H1N1 ☐ H1, Unspecified ☐ H3 ☐ Flu A, Unsubtypable ☐ Flu B, Yamagata
☐ Flu B, Victoria ☐ Negative ☐ Unknown Type ☐ 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) ☐ Flu B (no genotype) ☐ Flu A & B ☐ Flu A/B (Not Distinguished)
☐ 2009 H1N1 ☐ H1, Unspecified ☐ H3 ☐ Flu A, Unsubtypable ☐ Flu B, Yamagata
☐ Flu B, Victoria ☐ Negative ☐ Unknown Type ☐ Other, specify: _____

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

Case ID:__ __ 1 4 1 5 __ __

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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*	___ Myalgia/muscle aches	___ Shortness of breath/resp distress*
___ Chest pain	___ Diarrhea	___ Nausea/vomiting	___ Sore throat*
___ Congested/runny nose*	___ Fever/chills	___ Rash	___ Wheezing*
___ Conjunctivitis/pink eye	___ Headache	___ Seizures	___ Other, non-respiratory

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: ☐ Unk | **6. Height:** ☐ In ☐ Cm ☐ Unk | **7. Weight:** ☐ Lbs ☐ Kg ☐ Unk

8. Smoker: ☐ Current ☐ Former ☐ No/Unknown | **9. Alcohol abuse:** ☐ 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
- ☐ 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)
- ☐ 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*

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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. 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: ___/____/___ **2d. End Date:** ____/____/____ **2e. Dose:** _____ **2f. Frequency:** _____

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

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

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

☐ Start Date Unknown ☐ End Date Unknown ☐ Dose Unknown ☐ Frequency Unknown

6. Additional Treatment Comments:

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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	☐ Consolidation	☐ Interstitial infiltrate
☐ Air space density/opacity	☐ Atelectasis	☐ Pleural effusion/empyema
☐ Bronchopneumonia/pneumonia	☐ Cavitation	☐ Lobar infiltrate
☐ Cannot rule out pneumonia	☐ ARDS (acute respiratory distress syndrome)	☐ 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 ☐ Alcohol/Drug Abuse Treatment ☐ Assisted living/Residential Care ☐ Group home/Retirement home
☐ Home with Services ☐ Homeless/Shelter ☐ Jail/Prison ☐ LTACH/Transitional Care (TCU) ☐ Mental Hospital
☐ Nursing home ☐ Rehabilitation Facility ☐ Hospice ☐ Unknown ☐ Other, specify: _____

3. If patient was pregnant on admission, indicate pregnancy status atdischarge: ☐ 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: