U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
AND PREVENTION
ATLANTA, GA 30329

2018-19 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form

Form Approved
OMB No. 0920-0978

Case ID: 1 8 1 9

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

Last Name: _____ First Name: _____ Middle Name: _____ Chart No: _____

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

_____ _____ _____ Phone No. 1: _____
(City) (State) (Zip Code)

Phone No.2: _____ Emergency Contact: _____ Emergency Contact Phone: _____ ☐ No PCP

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

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

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

B. Abstractor Information – THIS INFORMATION IS NOT SENT TO CDC

1. Abstractor Name: _____ 2. Date of Abstraction: _____ / _____ / _____

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 discharged from any hospital within 1 week prior to the current admission date? ☐ Yes ☐ No ☐ Unknown

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

13a. Transfer Hospital ID: _____

13b. Transfer Hospital Admission Date: _____ / _____ / _____

13c. Transfer Date: _____ / _____ / _____

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

☐ Private residence
☐ Home with Services
☐ Homeless/Shelter
☐ Nursing home/Skilled Nursing Facility
☐ Alcohol/Drug Abuse Treatment
☐ Hospitalized at birth
☐ Rehabilitation facility
☐ Corrections Facility
☐ Other, specify: _____
☐ Hospice
☐ Assisted living/Residential care
☐ LTACH
☐ Group home/Retirement
☐ Psychiatric facility
☐ Unknown
☐ Other long term care facility

14a. If resident of a facility, indicate NAME of facility: _____

15. Type of Insurance: (Check all that apply):

☐ Private
☐ Medicare
☐ Medicaid/state assistance program
☐ Military
☐ Indian Health Service
☐ Incarcerated
☐ Uninsured
☐ Unknown
☐ Other, specify: _____

D. Influenza Testing Results (can add up to 4 test results in database)

1. Test 1: ☐ Rapid Antigen ☐ Molecular Assay ☐ Rapid Molecular Assay ☐ Viral Culture ☐ Serology ☐ Fluorescent Antibody ☐ Method Unknown

1a. Result: ☐ Flu A (no subtype) ☐ 2009 H1N1 ☐ H1, Unspecified ☐ H1, Seasonal ☐ H1 ☐ H3 ☐ Flu A, Unsubtypable ☐ Flu B (no lineage) ☐ Flu B, Victoria ☐ Flu B, Yamagata ☐ Flu A & B ☐ Flu A/B (Not Distinguished) ☐ Unknown Type ☐ Negative ☐ H3N2v ☐ Other, specify: _____

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

2. Test 2: ☐ Rapid Antigen ☐ Molecular Assay ☐ Rapid Molecular Assay ☐ Viral Culture ☐ Serology ☐ Fluorescent Antibody ☐ Method Unknown

2a. Result: ☐ Flu A (no subtype) ☐ 2009 H1N1 ☐ H1, Unspecified ☐ H1, Seasonal ☐ H1 ☐ H3 ☐ Flu A, Unsubtypable ☐ Flu B (no lineage) ☐ Flu B, Victoria ☐ Flu B, Yamagata ☐ Flu A & B ☐ Flu A/B (Not Distinguished) ☐ Unknown Type ☐ Negative ☐ H3N2v ☐ Other, specify: _____

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

3. Test 3: ☐ Rapid Antigen ☐ Molecular Assay ☐ Rapid Molecular Assay ☐ Viral Culture ☐ Serology ☐ Fluorescent Antibody ☐ Method Unknown

3a. Result: ☐ Flu A (no subtype) ☐ 2009 H1N1 ☐ H1, Unspecified ☐ H1, Seasonal ☐ H1 ☐ H3 ☐ Flu A, Unsubtypable ☐ Flu B (no lineage) ☐ Flu B, Victoria ☐ Flu B, Yamagata ☐ Flu A & B ☐ Flu A/B (Not Distinguished) ☐ Unknown Type ☐ Negative ☐ H3N2v ☐ Other, specify: _____

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

2018-19 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form

Case ID: ____ ____ 1 8 1 9 ____ ____ ____ ____

E. Admission and Patient History

1. Acute signs/symptoms present at admission *(began or worsened within 2 weeks prior to admission)*: ☐ **No Signs/Symptoms**

Non-respiratory symptoms	Respiratory symptoms		
___ Altered mental status/confusion	___ Congested/runny nose	___ Shortness of breath/respiratory distress	___ URI/ILI
___ Fever/chills	___ Cough	___ Sore throat	___ Wheezing
___ Seizures			

2. Date of onset of acute respiratory symptoms *(within 2 weeks before a positive flu test)*: ____ /____ /____ ☐ Unknown ☐ Not applicable

3. BMI: ____	4. Height: ____	5. Weight: ____	6. Smoker (tobacco):	7. Alcohol abuse:	8. Substance abuse:
☐ Unk	☐ In ☐ Cm ☐ Unk	☐ Lbs ☐ Kg ☐ Unk	☐ Current ☐ Former ☐ No/Unk	☐ Current ☐ Former ☐ No/Unk	☐ Current ☐ Former ☐ No/Unk

8a. Substance Abuse Type (current use only) (check all that apply):
☐ IVDU ☐ Opioids ☐ Other, specify: ____ ☐ Unknown

***(Optional)* 9. Current Non-Tobacco Smoker:** ☐ Yes ☐ No/Unknown
(check all that apply): ☐ Marijuana ☐ E-cigarettes ☐ Other

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
- ☐ Active Tuberculosis/TB
- ☐ Cystic fibrosis
- ☐ Emphysema/COPD
- ☐ Chronic bronchitis
- ☐ Chronic respiratory failure
- ☐ Other, specify: ____

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

10d. Blood disorders/Hemoglobinopathy ☐ Yes ☐ No/Unknown
- ☐ Aplastic anemia
- ☐ Sickle cell disease
- ☐ Splenectomy/Asplenia
- ☐ Other, specify: ____

10e. Cardiovascular Disease ☐ Yes ☐ No/Unknown
- ☐ Aortic aneurysm
- ☐ Aortic stenosis
- ☐ Atrial Fibrillation
- ☐ Cardiomyopathy
- ☐ Atherosclerotic cardiovascular disease (ASCVD)
- ☐ Cerebral vascular incident/Stroke
- ☐ Congenital heart disease
- ☐ Coronary artery disease (CAD)
- ☐ Ischemic cardiomyopathy
- ☐ Non-ischemic cardiomyopathy
- ☐ Heart failure/CHF
- ☐ Other, specify: ____

10f. Neuromuscular disorder ☐ Yes ☐ No/Unknown
- ☐ Duchenne muscular dystrophy
- ☐ Muscular dystrophy
- ☐ Multiple sclerosis
- ☐ Mitochondrial disorder
- ☐ Myasthenia gravis
- ☐ Parkinson's disease
- ☐ Other, specify: ____

10g. Neurologic disorder ☐ Yes ☐ No/Unknown
- ☐ Cerebral palsy
- ☐ Cognitive dysfunction
- ☐ Dementia/Alzheimer's disease
- ☐ 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. Liver disease ☐ Yes ☐ No/Unknown
- ☐ Cirrhosis
- ☐ Viral hepatitis (B or C)
- ☐ Other, specify: ____

10l. Any obesity ☐ Yes ☐ No/Unknown
- ☐ Obese
- ☐ Morbidly obese (ADULTS ONLY)

10m. Pregnant ☐ Yes ☐ No/Unknown

If pregnant,
Total # of pregnancies to date: ____ ☐ Unknown
Total # of pregnancies to date that resulted in a live birth: ____ ☐ Unknown
Specify total # of fetuses for current pregnancy:
☐ 1 ☐ 2 ☐ 3 ☐ >3 ☐ Unknown
Specify, gestational age in weeks: ____ ☐ Unknown
If gestational age in weeks unknown, specify trimester of pregnancy:
☐ 1st (0 to 13 6/7 weeks) ☐ 3rd (28 0/7 to end)
☐ 2nd (14 0/7 to 27 6/7 weeks) ☐ Unknown

10n. Post-partum (two weeks or less) ☐ Yes ☐ No/Unknown

10o. Other ☐ Yes ☐ No/Unknown
- ☐ Systemic lupus erythematosus/SLE/Lupus
- ☐ Other, specify: ____

10p. 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 (gestation age < 37 weeks at birth for patients < 2yrs)	☐ Yes	☐ No/Unknown

If yes, specify gestational age at birth in weeks: ____
☐ Unknown gestational age at birth

2018-19 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form

Case ID: ____ ____ 1 8 1 9 ____ ____ ____ ____

F. Intensive Care Unit and Interventions

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

1a. Date of first ICU Admission: ____/____/____ ☐ Unknown

1b. Date of first ICU Discharge: ____/____/____ ☐ Unknown

2. Did patient receive invasive 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* (can record up to 5 pathogens in database)

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:

_____

☐ Aspergillus (fungus)

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

4a. If yes, specify Pathogen 2:

_____

☐ Aspergillus (fungus)

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

H. Viral Pathogens

1. Was patient tested for any viral respiratory pathogens within 14 days prior to or within 3 days after 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 (can record up to 4 treatments in database)

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

2a. Treatment 1:
☐ Oseltamivir (Tamiflu)
☐ Peramivir (Rapivab)
☐ Zanamivir (Relenza)
☐ Other, specify: _____
☐ Unknown

2b. Start Date: ____/____/____ ☐ Start Date Unknown

2c. End Date: ____/____/____ ☐ End Date Unknown OR **Total Duration (days):** ____

3a. Treatment 2:
☐ Oseltamivir (Tamiflu)
☐ Peramivir (Rapivab)
☐ Zanamivir (Relenza)
☐ Other, specify: _____
☐ Unknown

3b. Start Date: ____/____/____ ☐ Start Date Unknown

3c. End Date: ____/____/____ ☐ End Date Unknown OR **Total Duration (days):** ____

4a. Treatment 3:
☐ Oseltamivir (Tamiflu)
☐ Peramivir (Rapivab)
☐ Zanamivir (Relenza)
☐ Other, specify: _____
☐ Unknown

4b. Start Date: ____/____/____ ☐ Start Date Unknown

4c. End Date: ____/____/____ ☐ End Date Unknown OR **Total Duration (days):** ____

5. 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
☐ Air space opacity
☐ Bronchopneumonia/pneumonia
☐ Cannot rule out pneumonia
☐ Consolidation
☐ Cavitation
☐ ARDS (acute respiratory distress syndrome)
☐ Lung infiltrate
☐ Interstitial infiltrate
☐ Lobar infiltrate
☐ Other

K. Discharge Summary

1. Did the patient have any of the following new diagnoses at discharge? (check all that apply) ☐ No discharge summary available

Acute encephalopathy/encephalitis	☐ Yes	☐ No/Unk	Bacteremia	☐ Yes	☐ No/Unk	Invasive pulmonary aspergillosis	☐ Yes	☐ No/Unk
Acute Myocardial Infarction	☐ Yes	☐ No/Unk	Bronchiolitis	☐ Yes	☐ No/Unk	Reyes syndrome	☐ Yes	☐ No/Unk
Acute Myocarditis	☐ Yes	☐ No/Unk	Congestive Heart Failure	☐ Yes	☐ No/Unk	Rhabdomyolysis	☐ Yes	☐ No/Unk
Acute Renal Failure/Acute Kidney Injury	☐ Yes	☐ No/Unk	COPD exacerbation	☐ Yes	☐ No/Unk	Pneumonia	☐ Yes	☐ No/Unk
Acute respiratory distress syndrome (ARDS)	☐ Yes	☐ No/Unk	Diabetic Ketoacidosis	☐ Yes	☐ No/Unk	Sepsis	☐ Yes	☐ No/Unk
Acute respiratory failure	☐ Yes	☐ No/Unk	Guillan-Barre syndrome	☐ Yes	☐ No/Unk	Seizures	☐ Yes	☐ No/Unk
Asthma exacerbation	☐ Yes	☐ No/Unk	Hemophagocytic syndrome	☐ Yes	☐ No/Unk	Stroke (CVA)	☐ Yes	☐ No/Unk

2. What was the outcome of the patient?

☐ Alive
☐ Deceased
☐ Unknown

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

☐ Private residence
☐ Home with services
☐ Homeless/Shelter
☐ Nursing home /Skilled Nursing Facility
☐ Alcohol/Drug Abuse Treatment
☐ Rehabilitation Facility
☐ Corrections Facility
☐ Hospice
☐ Assisted living/Residential care
☐ LTACH
☐ Group home/Retirement home
☐ Psychiatric Facility
☐ Unknown
☐ Other long term care facility
☐ 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 (intrauterine death at <22 weeks GA) ☐ Stillbirth (intrauterine death at ≥22 weeks GA)
☐ Ill newborn ☐ Newborn died ☐ Healthy newborn ☐ Abortion ☐ Unknown

3b. If no longer pregnant, indicate date of delivery or end of pregnancy: _____ /_____ /_____ ☐ Unknown

4. Additional notes regarding discharge:

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

☐ ICD codes not available

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 ☐ Unsuccessful Attempt

1a. If yes, specify dosage date information: _____/_____/_____ ☐ 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 ☐ Unsuccessful Attempt

2a. If yes, specify dosage date information: _____/_____/_____ ☐ Date Unknown

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

3. Primary Care Provider /LTCF: ☐ Yes, full date known ☐ Yes, specific date unknown ☐ No ☐ Unknown ☐ Not Checked ☐ Unsuccessful Attempt

3a. If yes, specify dosage date information: _____/_____/_____ ☐ 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 ☐ Unsuccessful Attempt

4a. If yes, specify dosage date information: _____/_____/_____ ☐ 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

6. If patient < 9 yrs, did patient receive 2nd influenza vaccine in current season? ☐ Yes ☐ No ☐ Unknown

6a. If yes, specify 2nd dosage date information: _____/_____/_____ ☐ Date Unknown

N. Miscellaneous

1. Additional Comments: