

2017-18 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form



Form Approved
OMB No. 0920-0978

Case ID: 1 7 1 8

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.)

(City) (State) (Zip Code) Phone No. 1: _____
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: <input type="checkbox"/> Prospective Surveillance <input type="checkbox"/> Discharge Audit		2. Admission Type: <input type="checkbox"/> Hospitalization <input type="checkbox"/> Observation Only		3. County: _____		4. State: _____		5. Case Type: <input type="checkbox"/> Pediatric <input type="checkbox"/> Adult	
6. Date of Birth: _____/_____/_____		7. Age: <input type="checkbox"/> Years <input type="checkbox"/> Days (if < 1 month) <input type="checkbox"/> Months (if < 1 yr)		8. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		9. Race: <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Multiracial <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Not specified			
10. Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 13. Was patient transferred from another hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.) <input type="checkbox"/> Private residence <input type="checkbox"/> Hospice <input type="checkbox"/> Homeless/Shelter <input type="checkbox"/> Assisted living/Residential care <input type="checkbox"/> Nursing home/Skilled Nursing Facility <input type="checkbox"/> LTACH <input type="checkbox"/> Alcohol/Drug Abuse Treatment <input type="checkbox"/> Group home/Retirement <input type="checkbox"/> Hospitalized at birth <input type="checkbox"/> Mental Hospital <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Unknown <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Other long term care facility <input type="checkbox"/> Other, specify: _____		15. Type of Insurance: (Check all that apply): <input type="checkbox"/> Private <input type="checkbox"/> Incarcerated <input type="checkbox"/> Medicare <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicaid/state assistance program <input type="checkbox"/> Unknown <input type="checkbox"/> Military <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Indian Health Service							
14a. If resident of a facility, indicate NAME of facility: _____									

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

1. Test 1: <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> Molecular Assay <input type="checkbox"/> Rapid Molecular Assay <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology <input type="checkbox"/> Fluorescent Antibody <input type="checkbox"/> Method Unknown									
1a. Result: <input type="checkbox"/> Flu A (no subtype) <input type="checkbox"/> H1, Seasonal <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B, Yamagata <input type="checkbox"/> Unknown Type <input type="checkbox"/> Other, specify: <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H1 <input type="checkbox"/> Flu B (no lineage) <input type="checkbox"/> Flu A & B <input type="checkbox"/> Negative <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> H3 <input type="checkbox"/> Flu B, Victoria <input type="checkbox"/> Flu A/B (Not Distinguished) <input type="checkbox"/> H3N2v									
1b. Specimen collection date: ____/____/____		1c. Testing facility ID: _____				1d. Specimen ID: _____			
2. Test 2: <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> Molecular Assay <input type="checkbox"/> Rapid Molecular Assay <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology <input type="checkbox"/> Fluorescent Antibody <input type="checkbox"/> Method Unknown									
2a. Result: <input type="checkbox"/> Flu A (no subtype) <input type="checkbox"/> H1, Seasonal <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B, Yamagata <input type="checkbox"/> Unknown Type <input type="checkbox"/> Other, specify: <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H1 <input type="checkbox"/> Flu B (no lineage) <input type="checkbox"/> Flu A & B <input type="checkbox"/> Negative <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> H3 <input type="checkbox"/> Flu B, Victoria <input type="checkbox"/> Flu A/B (Not Distinguished) <input type="checkbox"/> H3N2v									
2b. Specimen collection date: ____/____/____		2c. Testing facility ID: _____				2d. Specimen ID: _____			
3. Test 3: <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> Molecular Assay <input type="checkbox"/> Rapid Molecular Assay <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology <input type="checkbox"/> Fluorescent Antibody <input type="checkbox"/> Method Unknown									
3a. Result: <input type="checkbox"/> Flu A (no subtype) <input type="checkbox"/> H1, Seasonal <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B, Yamagata <input type="checkbox"/> Unknown Type <input type="checkbox"/> Other, specify: <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H1 <input type="checkbox"/> Flu B (no lineage) <input type="checkbox"/> Flu A & B <input type="checkbox"/> Negative <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> H3 <input type="checkbox"/> Flu B, Victoria <input type="checkbox"/> Flu A/B (Not Distinguished) <input type="checkbox"/> H3N2v									
3b. Specimen collection date: ____/____/____		3c. Testing facility ID: _____				3d. Specimen ID: _____			

E. Admission and Patient History

1. Date of onset of acute condition resulting in current hospitalization: _____ / _____ / _____ Unknown

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

Non-respiratory symptoms

- ___ Altered mental status/confusion ___ Fatigue/weakness ___ Nausea/vomiting
- ___ Chest pain ___ Fever/chills ___ Rash
- ___ Conjunctivitis/pink eye ___ Headache ___ Seizures
- ___ Diarrhea ___ Myalgia/muscle aches ___ Other, non-respiratory

Respiratory symptoms

- ___ Congested/runny nose ___ URI/ILI
- ___ Cough ___ Wheezing
- ___ Shortness of breath/respiratory distress
- ___ Sore throat

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

4. BMI: _____
 Unk

5. Height: _____
 In Cm Unk

6. Weight: _____
 Lbs Kg Unk

7. Smoker (tobacco):
 Current Former
 No/Unk

8. Alcohol abuse:
 Current Former
 No/Unk

9. Substance abuse:
 Current Former
 No/Unk

9a. Substance Abuse Type (current use only) (check all that apply):
 IVDU Opioids Other, specify: _____ Unknown

(Optional) 10. Current Non-Tobacco Smoker: Yes No/Unknown
(check all that apply): Marijuana E-cigarettes Other

11. Did patient have any of the following pre-existing medical conditions? Check all that apply. Yes No Unknown

11a. Asthma/Reactive Airway Disease Yes No/Unknown

11h History of Guillain-Barré Syndrome Yes No/Unknown

11b. Chronic Lung Disease Yes No/Unknown

11i. Immunocompromised Condition Yes No/Unknown

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

- 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: _____

11c. Chronic Metabolic Disease Yes No/Unknown

- Diabetes Mellitus
- Thyroid dysfunction
- Other, specify: _____

11d. Blood disorders/Hemoglobinopathy Yes No/Unknown

- Aplastic anemia
- Sickle cell disease
- Splenectomy/Asplenia
- Other, specify: _____

11j. Renal Disease Yes No/Unknown

- Chronic kidney disease/chronic renal insufficiency
- End stage renal disease/Dialysis
- Glomerulonephritis
- Nephrotic syndrome
- Other, specify: _____

11e. 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: _____

11k. Liver disease Yes No/Unknown

- Cirrhosis
- Viral hepatitis (B or C)
- Other, specify: _____

11f. Neuromuscular disorder Yes No/Unknown

- Duchenne muscular dystrophy
- Muscular dystrophy
- Multiple sclerosis
- Mitochondrial disorder
- Myasthenia gravis
- Parkinson's disease
- Other, specify: _____

11l. Any obesity Yes No/Unknown

- Obese
- Morbidly obese (ADULTS ONLY)

11g. Neurologic disorder Yes No/Unknown

- Cerebral palsy
- Cognitive dysfunction
- Dementia/Alzheimer's disease
- Developmental delay
- Down syndrome
- Plegias/Paralysis
- Seizure/Seizure disorder
- Other, specify: _____

11m. Pregnant Yes No/Unknown

- If pregnant, specify gestational age in weeks: _____
- Unknown gestational age

11n. Post-partum (two weeks or less) Yes No/Unknown

11o. Other Yes No/Unknown

- Systemic lupus erythematosus/SLE/Lupus
- Other, specify: _____

11p. 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

F. Intensive Care Unit and Interventions (can record up to 3 ICU stays in database)

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 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: _____
 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: _____
 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 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 (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) Zanamivir (Relenza) Unknown
 Peramivir (Rapivab) Other, specify: _____
 2b. Method of Administration: Oral Intravenous (IV) Inhaled Unknown
 2c. Start Date: _____/_____/_____ 2d. End Date: _____/_____/_____
 Start Date Unknown End Date Unknown
 2e. Dose: 75 mg 60 mg 30 mg 3 mg/kg/dose 45 mg Dose Unknown Other _____
 2f. Frequency: QD QOD BID Frequency Unknown TID Other _____
 3a. Treatment 2: Oseltamivir (Tamiflu) Zanamivir (Relenza) Unknown
 Peramivir (Rapivab) Other, specify: _____
 3b. Method of Administration: Oral Intravenous (IV) Inhaled Unknown
 3c. Start Date: _____/_____/_____ 3d. End Date: _____/_____/_____
 Start Date Unknown End Date Unknown
 3e. Dose: 75 mg 60 mg 30 mg 3 mg/kg/dose 45 mg Dose Unknown Other _____
 3f. Frequency: QD QOD BID Frequency Unknown TID Other _____
 4a. Treatment 3: Oseltamivir (Tamiflu) Zanamivir (Relenza) Unknown
 Peramivir (Rapivab) Other, specify: _____
 4b. Method of Administration: Oral Intravenous (IV) Inhaled Unknown
 4c. Start Date: _____/_____/_____ 4d. End Date: _____/_____/_____
 Start Date Unknown End Date Unknown
 4e. Dose: 75 mg 60 mg 30 mg 3 mg/kg/dose 45 mg Dose Unknown Other _____
 4f. Frequency: QD QOD BID Frequency Unknown TID Other _____

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:

<input type="checkbox"/> Report not available	<input type="checkbox"/> Cannot rule out pneumonia	<input type="checkbox"/> Lung infiltrate
<input type="checkbox"/> Air space density	<input type="checkbox"/> Consolidation	<input type="checkbox"/> Interstitial infiltrate
<input type="checkbox"/> Air space opacity	<input type="checkbox"/> Cavitation	<input type="checkbox"/> Lobar infiltrate
<input type="checkbox"/> Bronchopneumonia/pneumonia	<input type="checkbox"/> ARDS (acute respiratory distress syndrome)	<input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk	Bacteremia <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk	Reyes syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk
Acute Myocardial Infarction <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk	Bronchiolitis <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk	Rhabdomyolysis <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk
Acute Myocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk	Congestive Heart Failure <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk
Acute Renal Failure/Acute Kidney Injury <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk	COPD exacerbation <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk	Sepsis <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk
Acute respiratory distress syndrome (ARDS) <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk	Diabetic Ketoacidosis <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk	Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk
Acute respiratory failure <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk	Guillan-Barre syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk	Stroke (CVA) <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk
Asthma exacerbation <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk	Hemophagocytic syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No/Unk	

2. What was the outcome of the patient?

<input type="checkbox"/> Alive	<input type="checkbox"/> Private residence	<input type="checkbox"/> Rehabilitation Facility	<input type="checkbox"/> Group home/Retirement home
<input type="checkbox"/> Deceased	<input type="checkbox"/> Homeless/Shelter	<input type="checkbox"/> Jail/Prison	<input type="checkbox"/> Mental Hospital
<input type="checkbox"/> Unknown	<input type="checkbox"/> Nursing home /Skilled Nursing Facility	<input type="checkbox"/> Hospice	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Alcohol/Drug Abuse Treatment	<input type="checkbox"/> Assisted living/Residential care	<input type="checkbox"/> Other, specify: _____
	<input type="checkbox"/> Home with services	<input type="checkbox"/> LTACH	

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-10 Discharge Diagnoses – To be recorded in order of appearance

<input type="checkbox"/> 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: