

# 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.)  
\_\_\_\_\_  
(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

<b>1. Case Classification:</b> <input type="checkbox"/> Prospective Surveillance <input type="checkbox"/> Discharge Audit	<b>2. Admission Type:</b> <input type="checkbox"/> Hospitalization <input type="checkbox"/> Observation Only	<b>3. County:</b> _____	<b>4. State:</b> _____	<b>5. Case Type:</b> <input type="checkbox"/> Pediatric <input type="checkbox"/> Adult
<b>6. Date of Birth:</b> ____ / ____ / ____	<b>7. Age:</b> <input type="checkbox"/> Years <input type="checkbox"/> Days (if < 1 month) <input type="checkbox"/> Months (if < 1 yr)	<b>8. Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>9. Race:</b> <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	
<b>10. Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Not Specified	<b>11. Hospital ID Where Patient Treated:</b> _____ <b>11a. Admission Date:</b> ____ / ____ / ____ <b>11b. Discharge Date:</b> ____ / ____ / ____		<b>12. Was patient discharged from any hospital within 1 week prior to the current admission date?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>14. Where did patient reside at the time of hospitalization?</b> (Indicate TYPE of residence.) <input type="checkbox"/> Private residence <input type="checkbox"/> Hospice <input type="checkbox"/> Home with Services <input type="checkbox"/> Assisted living/Residential care <input type="checkbox"/> Homeless/Shelter <input type="checkbox"/> LTACH <input type="checkbox"/> Nursing home/Skilled Nursing Facility <input type="checkbox"/> Group home/Retirement <input type="checkbox"/> Alcohol/Drug Abuse Treatment <input type="checkbox"/> Psychiatric facility <input type="checkbox"/> Hospitalized at birth <input type="checkbox"/> Unknown <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Other long term care facility <input type="checkbox"/> Corrections Facility <input type="checkbox"/> Other, specify: _____		<b>13. Was patient transferred from another hospital?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>13a. Transfer Hospital ID:</b> _____ <b>13b. Transfer Hospital Admission Date:</b> ____ / ____ / ____ <b>13c. Transfer Date:</b> ____ / ____ / ____		
<b>14a. If resident of a facility, indicate NAME of facility:</b> _____		<b>15. Type of Insurance:</b> (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		

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

<b>1. Test 1:</b> <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			
<b>1a. Result:</b> <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			
<b>1b. Specimen collection date:</b> ____ / ____ / ____	<b>1c. Testing facility ID:</b> _____	<b>1d. Specimen ID:</b> _____	
<b>2. Test 2:</b> <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			
<b>2a. Result:</b> <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			
<b>2b. Specimen collection date:</b> ____ / ____ / ____	<b>2c. Testing facility ID:</b> _____	<b>2d. Specimen ID:</b> _____	
<b>3. Test 3:</b> <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			
<b>3a. Result:</b> <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			
<b>3b. Specimen collection date:</b> ____ / ____ / ____	<b>3c. Testing facility ID:</b> _____	<b>3d. Specimen ID:</b> _____	

**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**

- Altered mental status/confusion
- Fever/chills
- Seizures

**Respiratory symptoms**

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

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

<b>3. BMI:</b> _____ <input type="checkbox"/> Unk	<b>4. Height:</b> _____ <input type="checkbox"/> In <input type="checkbox"/> Cm <input type="checkbox"/> Unk	<b>5. Weight:</b> _____ <input type="checkbox"/> Lbs <input type="checkbox"/> Kg <input type="checkbox"/> Unk	<b>6. Smoker (tobacco):</b> <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> No/Unk	<b>7. Alcohol abuse:</b> <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> No/Unk	<b>8. Substance abuse:</b> <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> No/Unk
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**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

**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: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

3d. If *Staphylococcus aureus*, specify:  Methicillin resistant (MRSA)  Methicillin sensitive (MSSA)  Sensitivity unknown

3c. Site where pathogen identified:

- Blood
- Bronchoalveolar lavage (BAL)
- Pleural fluid
- Other, specify: \_\_\_\_\_
- Cerebrospinal fluid (CSF)
- Sputum
- Endotracheal aspirate

4a. If yes, specify Pathogen 2:

Aspergillus (fungus)

4b. Date of culture: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

4d. If *Staphylococcus aureus*, specify:  Methicillin resistant (MRSA)  Methicillin sensitive (MSSA)  Sensitivity unknown

4c. Site where pathogen identified:

- Blood
- Bronchoalveolar lavage (BAL)
- Pleural fluid
- Other, specify: \_\_\_\_\_
- Cerebrospinal fluid (CSF)
- Sputum
- Endotracheal aspirate

**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

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

2a. Date of first abnormal chest x-ray:  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_

**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	Invasive pulmonary aspergillosis	<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	Reyes syndrome	<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	Rhabdomyolysis	<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	Pneumonia	<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	Sepsis	<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	Seizures	<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	Stroke (CVA)	<input type="checkbox"/> Yes <input type="checkbox"/> No/Unk

2. What was the outcome of the patient?

Alive  
 Deceased  
 Unknown

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

<input type="checkbox"/> Private residence	<input type="checkbox"/> Rehabilitation Facility	<input type="checkbox"/> Group home/Retirement home
<input type="checkbox"/> Home with services	<input type="checkbox"/> Corrections Facility	<input type="checkbox"/> Psychiatric Facility
<input type="checkbox"/> Homeless/Shelter	<input type="checkbox"/> Hospice	<input type="checkbox"/> Unknown
<input type="checkbox"/> Nursing home /Skilled Nursing Facility	<input type="checkbox"/> Assisted living/Residential care	<input type="checkbox"/> Other long term care facility
<input type="checkbox"/> Alcohol/Drug Abuse Treatment	<input type="checkbox"/> LTACH	<input type="checkbox"/> 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 2<sup>nd</sup> influenza vaccine in current season?  Yes  No  Unknown

6a. If yes, specify 2<sup>nd</sup> dosage date information: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Date Unknown

**N. Miscellaneous**

1. Additional Comments: