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

# 2019-20 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form

**Case ID:** ____ ____ 1 9 2 0 ____ ____ ____ ____

Form Approved
OMB No. 0920-0978

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

Last Name: ______ First Name: ______ Middle Name: ______ Chart No: ______

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

______ (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:** ☐ 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 ☐ Months (if < 1 yr) ☐ Days (if < 1 month)

**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:** ______

Public reporting burden of this collection of information is estimated to average 17 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Request Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0978).

## 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 ☐ Cocaine ☐ Methamphetamines ☐ Marijuana (ingested or unknown route) ☐ Other, specify: ________________ ☐ Unknown

**9. Current Non-Tobacco Smoker:** ☐ Yes ☐ No/Unknown **(check all that apply):** ☐ Marijuana ☐ E-nicotine delivery system (ENDS) ☐ 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
- ☐ Asbestosis
- ☐ Bronchiectasis
- ☐ Bronchiolitis obliterans
- ☐ Chronic bronchitis
- ☐ Chronic respiratory failure
- ☐ Cystic fibrosis (CF)
- ☐ Emphysema/Chronic obstructive pulmonary disease (COPD)
- ☐ Interstitial lung disease (ILD)
- ☐ Oxygen ($O_2$) dependent
- ☐ Obstructive sleep apnea (OSA)
- ☐ Pulmonary fibrosis
- ☐ Restrictive lung disease
- ☐ Sarcoidosis
- ☐ Other, specify: ____________________

**10c. Chronic Metabolic Disease** ☐ **Yes** ☐ **No/Unknown**

- ☐ Adrenal Disorders (Addison's, Adrenal insufficiency, Cushing syndrome, Congenital adrenal hyperplasia)
- ☐ Diabetes mellitus (DM)
- ☐ Glycogen or other storage diseases (see list)
- ☐ Hyper/Hypo function of pituitary gland
- ☐ Inborn errors of metabolism (see list)
- ☐ Metabolic syndrome
- ☐ Parathyroid dysfunction (Hyperparathyroidism, Hypoparathyroidism)
- ☐ Thyroid dysfunction (Grave's disease, Hashimoto's disease, Hyperthyroidism, Hypothyroidism)
- ☐ Other, specify: ____________________

**10d. Blood Disorders/Hemoglobinopathy** ☐ **Yes** ☐ **No/Unknown**

- ☐ Alpha thalassemia
- ☐ Aplastic anemia
- ☐ Beta thalassemia
- ☐ Coagulopathy (Factor V Leiden, Von Willebrand disease (VWD), see list)
- ☐ Hemoglobin S-beta thalassemia
- ☐ Leukopenia
- ☐ Myelodysplastic syndrome (MDS)
- ☐ Neutropenia
- ☐ Pancytopenia
- ☐ Polycythemia vera
- ☐ Sickle cell disease
- ☐ Splenectomy/Asplenia
- ☐ Thrombocytopenia
- ☐ Other, specify: ____________________

**10e. Cardiovascular Disease** ☐ **Yes** ☐ **No/Unknown**

- ☐ Aortic aneurysm (AAA), history of
- ☐ Aortic regurgitation (AR)
- ☐ Aortic stenosis (AS)
- ☐ Atherosclerotic cardiovascular disease (ASCVD)
- ☐ Atrial fibrillation (AFib)
- ☐ Atrioventricular (AV) blocks
- ☐ Automated implantable devices (AID/AICD)/Pacemaker
- ☐ Bundle branch block (BBB/RBBB/LBBB)
- ☐ Cardiomyopathy
- ☐ Carotid stenosis
- ☐ Cerebral vascular accident (CVA)/Incident/Stroke, history of
- ☐ Congenital heart disease (Specify)
  - ☐ Atrial septal defect
  - ☐ Pulmonic stenosis
  - ☐ Tetralogy of Fallot
  - ☐ Ventricular septal defect
  - ☐ Other, specify: ____________________
- ☐ Coronary artery bypass grafting (CABG), history of
- ☐ Coronary artery disease (CAD)
- ☐ Deep vein thrombosis (DVT), history of
- ☐ Heart failure/Congestive heart failure (CHF)
- ☐ Myocardial infarction (MI), history of
- ☐ Mitral stenosis (MS)
- ☐ Mitral regurgitation (MR)
- ☐ Peripheral artery disease (PAD)
- ☐ Peripheral vascular disease (PVD)
- ☐ Pulmonary embolism (PE), history of
- ☐ Pulmonary hypertension (PHTN)
- ☐ Pulmonic stenosis
- ☐ Pulmonic regurgitation
- ☐ Transient ischemic attack (TIA), history of
- ☐ Tricuspid stenosis
- ☐ Tricuspid regurgitation (TR)
- ☐ Aortic/Mitral/Tricuspid/Pulmonic valve replacement, history of
- ☐ Ventricular tachycardia (VT, VTach), history of
- ☐ Ventricular fibrillation (VF, VFib), history of
- ☐ Other, specify: ____________________

**10f. Neuromuscular Disorder** ☐ **Yes** ☐ **No/Unknown**

- ☐ Amyotrophic lateral sclerosis (ALS)
- ☐ Mitochondrial disorder (see list)
- ☐ Multiple sclerosis (MS)
- ☐ Muscular dystrophy (see list)
- ☐ Myasthenia gravis (MG)
- ☐ Parkinson's disease
- ☐ Scoliosis/Kyphoscoliosis
- ☐ Other, specify: ____________________

## E. Admission and Patient History *(continued)*

**10g. Neurologic Disorder** ☐ Yes ☐ No/Unknown

- ☐ Cerebral palsy
- ☐ Cognitive dysfunction
- ☐ Dementia/Alzheimer's disease
- ☐ Developmental delay
- ☐ Down syndrome/Trisomy 21
- ☐ Edwards syndrome/Trisomy 18
- ☐ Epilepsy/Seizure/Seizure disorder
- ☐ Neuropathy
- ☐ Neural tube defects/spina bifida (see list)
- ☐ Plegias/Paralysis/Quadriplegia
- ☐ Traumatic brain injury (TBI), history of
- ☐ Other, specify ____________

**10h. History of Guillan Barre Syndrome** ☐ Yes ☐ No/Unknown

**10i. Immunocompromised Condition** ☐ Yes ☐ No/Unknown

- ☐ AIDS or CD4 count<200
- ☐ Complement deficiency (See list)
- ☐ Graft vs. host disease (GVHD)
- ☐ HIV infection
- ☐ Immunoglobulin deficiency/ immunodeficiency (See list)
- ☐ Immunosuppressive therapy (within the 12 months prior to admission (See instructions)
  - ☐ If yes, For what condition?: ____________
- ☐ Leukemia*
- ☐ Lymphoma/Hodgkins/Non-Hodgkins (NHL)*
- ☐ Metastatic cancer*
- ☐ Multiple myeloma*
- ☐ Solid organ malignancy*
  - ☐ If yes, which organ? ____________
- ☐ Steroid therapy (within 2 weeks of admission)
- ☐ Transplant, hematopoietic stem cell (Bone marrow transplant (BMT), peripheral stem cell transplant (PSCT)), history of
- ☐ Transplant, solid organ (SOT), history of
- ☐ Other, specify: ____________

**Current/in treatment or diagnosed in last 12 months*

**10j. Renal Disease** ☐ Yes ☐ No/Unknown

- ☐ Chronic kidney disease (CKD)/chronic renal insufficiency (CRI)
- ☐ End stage renal disease (ESRD)
- ☐ Dialysis (HD)
- ☐ Glomerulonephritis (GN)
- ☐ Nephrotic syndrome
- ☐ Polycystic kidney disease (PCKD)
- ☐ Other, specify: ____________

**10k. Gastrointestinal/Liver Disease (Do Not Record GERD)** ☐ Yes ☐ No/Unknown

- ☐ Alcoholic hepatitis
- ☐ Autoimmune hepatitis
- ☐ Barrett's esophagitis
- ☐ Chronic liver disease
- ☐ Chronic pancreatitis
- ☐ Cirrhosis/End stage liver disease (ESLD)
- ☐ Crohn's disease
- ☐ Esophageal varices
- ☐ Esophageal strictures
- ☐ Hepatitis B, chronic (HBV)
- ☐ Hepatitis C, chronic (HCV)
- ☐ Non-alcoholic fatty liver disease/NASH/NAFLD
- ☐ Ulcerative colitis (UC)
- ☐ 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. Rheumatologic/ Autoimmune/Inflammatory Conditions(Do not record Osteoarthritis/OA)** ☐ Yes ☐ No/Unknown

- ☐ Ankylosing spondylitis
- ☐ Dermatomyositis
- ☐ Juvenile idiopathic arthritis
- ☐ Kawasaki disease
- ☐ Microscopic polyangiitis
- ☐ Polyarteritis nodosum (PAN)
- ☐ Polymyalgia rheumatica
- ☐ Polymyositis
- ☐ Psoriatic arthritis
- ☐ Rheumatoid arthritis (RA)
- ☐ Systemic lupus erythematosus/SLE/Lupus
- ☐ Systemic sclerosis
- ☐ Takayasu arteritis
- ☐ Temporal/Giant cell arteritis
- ☐ Vasculitis, other (see list)
- ☐ Other, specify ____________

**10p. Other** ☐ Yes ☐ No/Unknown

- ☐ Feeding tube dependent (PEG, see list)
- ☐ Trach dependent/Vent dependent
- ☐ Wheelchair dependent
- ☐ Other, specify ____________

**10q. PEDIATRIC CASES ONLY**

Abnormality of Airway (see instructions) ☐ Yes ☐ No/Unknown

Chronic Lung Disease of Prematurity/ Bronchopulmonary dysplasia (BPD) ☐ Yes ☐ No/Unknown

History of Febrile Seizures ☐ Yes ☐ No/Unknown

Long term Aspirin Therapy ☐ Yes ☐ No/Unknown

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

If yes, specify gestational age at birth in weeks: ________

☐ Unknown gestational age at birth

## 2019-20 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form

Case ID: ____ ____ 1 9 2 0 ____ ____ ____ ____

### 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
☐ Bronchoalveolar lavage (BAL)
☐ Pleural fluid
☐ Other, specify: ______________________
☐ Cerebrospinal fluid (CSF)
☐ Sputum
☐ Endotracheal aspirate

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
☐ Bronchoalveolar lavage (BAL)
☐ Pleural fluid
☐ Other, specify: ______________________
☐ Cerebrospinal fluid (CSF)
☐ Sputum
☐ Endotracheal aspirate

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

| Pathogen | | | | Date |
|---|---|---|---|---|
| 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)
☐ Baloxavir marboxil (Xofluza)
☐ 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)
☐ Baloxavir marboxil (Xofluza)
☐ 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)
☐ Baloxavir marboxil (Xofluza)
☐ 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
☐ Other
☐ Pleural Effusion/Empyema

## K. Discharge Summary

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

| Diagnosis | | | Diagnosis | | | Diagnosis | | |
|---|---|---|---|---|---|---|---|---|
| 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:**