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

Form Approved
OMB No. 0920-0978

Case ID: 1 9 2 0

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:** _____

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. <u>PEDIATRIC CASES ONLY</u>

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

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)
☐ 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:

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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
- ☐ 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

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: