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

2020-21 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form

FORM APPROVED
OMB NO. 0920-0978

FluSurv-NET Case ID: 2021 **COVID-NET Case ID:** **RSV-NET Case ID:**

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

Last Name:	First Name:	Middle Name:	Chart Number:
Address:		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:	CDCTrack:

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. State:

4. County:

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/Latino
☐ Not Specified

11. Type of Insurance *(select all that apply)*:
☐ Private
☐ Medicare
☐ Medicaid/state assistance program
☐ Military
☐ Indian Health Service
☐ Incarcerated
☐ Uninsured
☐ Unknown
☐ Other, specify: ____

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

13. Hospital ID Where Patient Treated: ____

13a. Admission Date: ____ / ____ / ____

13b. Discharge Date: ____ / ____ / ____

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

14a. Transfer Hospital ID: ____

14b. Transfer Hospital Admission Date: ____ / ____ / ____

14c. Transfer Date: ____ / ____ / ____

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

☐ Private residence	☐ Alcohol/Drug Abuse Treatment	☐ Hospice	☐ Psychiatric facility
☐ Private residence with services	☐ Hospitalized at birth	☐ Assisted living/Residential care	☐ Other long term care facility
☐ Homeless/shelter	☐ Rehabilitation facility	☐ LTACH	☐ Other, specify: ____
☐ Nursing home/Skilled nursing facility	☐ Corrections facility	☐ Group/Retirement home	☐ Unknown

15a. 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: ☐ Rapid Antigen ☐ Molecular Assay ☐ Rapid Molecular Assay ☐ Viral Culture ☐ Serology ☐ Fluorescent Antibody ☐ Method Unknown

1a. Result:

☐ Flu A (no subtype)	☐ H1, Seasonal	☐ Flu A, Unsubtypable	☐ Flu B, Yamagata	☐ Unknown Type	☐ Other, please specify:
☐ 2009 H1N1	☐ H1	☐ Flu B (no lineage)	☐ Flu A & B	☐ Negative	____
☐ H1, Unspecified	☐ H3	☐ Flu B, Victoria	☐ Flu A/B (not distiguished)	☐ H3N2v	

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

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

2a. Result:

☐ Flu A (no subtype)	☐ H1, Seasonal	☐ Flu A, Unsubtypable	☐ Flu B, Yamagata	☐ Unknown Type	☐ Other, please specify:
☐ 2009 H1N1	☐ H1	☐ Flu B (no lineage)	☐ Flu A & B	☐ Negative	____
☐ H1, Unspecified	☐ H3	☐ Flu B, Victoria	☐ Flu A/B (not distiguished)	☐ H3N2v	

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

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

3a. Result:

☐ Flu A (no subtype)	☐ H1, Seasonal	☐ Flu A, Unsubtypable	☐ Flu B, Yamagata	☐ Unknown Type	☐ Other, please specify:
☐ 2009 H1N1	☐ H1	☐ Flu B (no lineage)	☐ Flu A & B	☐ Negative	____
☐ H1, Unspecified	☐ H3	☐ Flu B, Victoria	☐ Flu A/B (not distiguished)	☐ H3N2v	

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

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E. ICU and Other Interventions

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

1a. Date of 1st ICU Admission: ____ / ____ / ____ ☐ Unknown **1b. Date of 1st ICU Discharge:** ____ / ____ / ____ ☐ Unknown

2. BiPAP or CPAP use? ☐ Yes ☐ No ☐ Unknown

3. High flow nasal cannula (e.g., Vapotherm)? ☐ Yes ☐ No ☐ Unknown

4. Invasive mechanical ventilation? ☐ Yes ☐ No ☐ Unknown

5. ECMO? ☐ Yes ☐ No ☐ Unknown

6. Vasopressor use? ☐ Yes ☐ No ☐ Unknown
(Common vasopressors are Dobutamine, Dopamine, Epinephrine, Milrinone, Neosynephrine, Norepinephrine, Vasopressin)

7. Renal Replacement Therapy (RRT) or Dialysis? ☐ Yes ☐ No ☐ Unknown
Includes Peritoneal Dialysis (PD), Hemodialysis (HD), Continuous Venovenous Hemofiltration (CVVH), Continuous Venovenous Hemodialysis (CVVHD), and Slow Continuous Ultrafiltration (SCUF)

F. Outcome

1. What was the outcome of the patient upon discharge? ☐ Alive ☐ Died during hospitalization ☐ Unknown

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

☐ Private residence
☐ Private residence with services
☐ Homeless/Shelter
☐ Nursing home/Skilled nursing facility
☐ Alcohol/Drug Abuse Treatment
☐ Rehabilitation facility
☐ Corrections facility
☐ Hospice
☐ Assisted living/Residential care
☐ LTACH
☐ Group/Retirement home
☐ Psychiatric facility
☐ Other long term care facility
☐ Against medical advice (AMA)
☐ Discharged to another hospital
☐ Other, specify:_____
☐ Unknown

3. Additional notes regarding discharge:

G. Admission and Patient History

1. Acute signs/symptoms present at admission (began or worsened within 2 weeks prior to admission) (*Select all that apply):* ☐ None of the below signs/symptoms

Non-respiratory symptoms

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

Respiratory symptoms

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

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

3. Height _____ ☐ Inch ☐ Cm ☐ Unknown

4. Weight _____ ☐ Lbs ☐ Kg ☐ Unknown

5. BMI (non-pregnant cases and cases ≥ 2 years only) _____ ☐ Unknown

6. Smoker (tobacco): ☐ Current ☐ Former ☐ No/Unknown

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H. Underlying Medical Conditions

1. Did the patient have any of the following pre-existing medical conditions? (*Select all that apply):* ☐ Yes ☐ No ☐ Unknown

1a. Asthma/Reactive Airway Disease: ☐ Yes ☐ No/Unknown

1b. 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)
- ☐ Obstructive sleep apnea (OSA)
- ☐ Oxygen (O_2) dependent
- ☐ Pulmonary fibrosis
- ☐ Restrictive lung disease
- ☐ Sarcoidosis
- ☐ Other, specifiy: _____

1c. Chronic Metabolic Disease: ☐ Yes ☐ No/Unknown

- ☐ Adrenal Disorders *(Addison's disease, 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, specifiy: _____

1d. 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, specifiy: _____

1e. Cardiovascular Disease: ☐ Yes ☐ No/Unknown

- ☐ Aortic aneurysm (AAA), history of
- ☐ Aortic/Mitral/Tricuspid/Pulmonic valve replacement, 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

1e. Cardiovascular Disease, continued:

- ☐ 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 regurgitation (MR)
- ☐ Mitral stenosis (MS)
- ☐ Peripheral artery disease (PAD)
- ☐ Peripheral vascular disease (PVD)
- ☐ Pulmonary embolism (PE), history of
- ☐ Pulmonary hypertension (PHTN)
- ☐ Pulmonic regurgitation
- ☐ Pulmonic stenosis
- ☐ Transient ischemic attack (TIA), history of
- ☐ Tricuspid regurgitation (TR)
- ☐ Tricuspid stenosis
- ☐ Ventricular fibrillation (VF, VFib), history of
- ☐ Ventricular tachycardia (VT, VTach), history of
- ☐ Other, specifiy: _____

1f. Neurologic Disorder: ☐ Yes ☐ No/Unknown

- ☐ Amyotrophic lateral sclerosis (ALS)
- ☐ Cerebral palsy
- ☐ Cognitive dysfunction
- ☐ Dementia/Alzheimer's disease
- ☐ Developmental delay
- ☐ Down syndrome/Trisomy 21
- ☐ Edward's syndrome/Trisomy 18
- ☐ Epilepsy/seizure/seizure disorder
- ☐ Mitochondrial disorder *(See list)*
- ☐ Multiple sclerosis (MS)
- ☐ Muscular dystrophy *(See list)*
- ☐ Myasthenia gravis (MG)
- ☐ Neural tube defects/Spina bifida *(See list)*
- ☐ Neuropathy
- ☐ Parkinson's disease
- ☐ Plegias/Paralysis/Quadriplegia
- ☐ Scoliosis/Kyphoscoliosis
- ☐ Traumatic brain injury (TBI), history of
- ☐ Other, specifiy: _____

1g. History of Guillain-Barre Syndrome: ☐ Yes ☐ No/Unknown

1h. 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 previous 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) (see instructions)*
- ☐ Transplant, hematopoietic stem cell *(bone marrow transplant (BMT), peripheral stem cell transplant (PSCT))*, history of
- ☐ Transplant, solid organ (SOT), history of
- ☐ Other, specifiy: _____

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

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H. Underlying Medical Conditions (continued)

1i. Any Obesity? ☐ Yes ☐ No/Unknown

- ☐ Obese
- ☐ Morbidly obese (ADULTS ONLY)

1j. Pregnant? ☐ Yes ☐ No/Unknown

1k. Post-Partum (two weeks or less) ☐ Yes ☐ No/Unknown

1l. Renal Disease ☐ Yes ☐ No/Unknown

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

1m. 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 (NAFLD)/NASH
- ☐ Ulcerative colitis (UC)
- ☐ Other, specifiy: _____

1n. Rheumatologic/Autoimmune/Inflammatory Conditions (Do Not Record 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, specifiy: _____

1o. Hypertension: ☐ Yes ☐ No/Unknown

1p. Other: ☐ Yes ☐ No/Unknown

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

1q. PEDIATRIC CASES ONLY

- ☐ Abnormality of airway *(see instructions)*
- ☐ Chronic lung disease of prematurity/Bronchopulmonary dysplasia (BPD)
- ☐ History of febrile seizures
- ☐ Long term aspirin therapy
- ☐ Premature *(gestation age <37 weeks at birth for patients < 2 years)*
  - If yes, specify gestational age at birth in weeks: _____
  - ☐ Unknown gestational age at birth

I. Viral Pathogens

1. Was patient tested for any of the following viral respiratory pathogens within 14 days prior to or within 7 days after admission, and if deceased, 14 days prior to death or 24 hours after death? ☐ Yes ☐ No ☐ Unknown

1a. Respiratory syncytial virus/RSV	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____ / ____ / ____
1b. Coronavirus SARS-CoV-2	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____ / ____ / ____

J. Influenza Treatment (can add up to 4 treatment courses in database)

1. Did the patient receive treatment for influenza? ☐ Yes ☐ No ☐ Unknown

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

1b. Start date: ____ / ____ / ____ ☐ Unknown **1c. End date:** ____ / ____ / ____ ☐ Unknown

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

2b. Start date: ____ / ____ / ____ ☐ Unknown **2c. End date:** ____ / ____ / ____ ☐ Unknown

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K. Discharge Summary

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

Acute encephalopathy/encephalitis	☐ Yes	☐ No/Unknown	Disseminated intravascular coagulation (DIC)	☐ Yes	☐ No/Unknown
Acute liver failure	☐ Yes	☐ No/Unknown	Guillain-Barre syndrome	☐ Yes	☐ No/Unknown
Acute myocardial infarction	☐ Yes	☐ No/Unknown	Hemophagocytic syndrome	☐ Yes	☐ No/Unknown
Acute myocarditis	☐ Yes	☐ No/Unknown	Invasive pulmonary aspergillosis	☐ Yes	☐ No/Unknown
Acute renal failure/acute kidney injury	☐ Yes	☐ No/Unknown	Kawasaki disease	☐ Yes	☐ No/Unknown
Acute respiratory distress syndrome (ARDS)	☐ Yes	☐ No/Unknown	Multisystem inflammatory syndrome in children (MIS-C)	☐ Yes	☐ No/Unknown
Acute respiratory failure	☐ Yes	☐ No/Unknown	Other thrombosis/embolism/coagulopathy	☐ Yes	☐ No/Unknown
Asthma exacerbation	☐ Yes	☐ No/Unknown	Pneumonia	☐ Yes	☐ No/Unknown
Bacteremia	☐ Yes	☐ No/Unknown	Pulmonary embolism (PE)	☐ Yes	☐ No/Unknown
Bronchiolitis	☐ Yes	☐ No/Unknown	Reyes Syndrome	☐ Yes	☐ No/Unknown
Bronchitis	☐ Yes	☐ No/Unknown	Rhabdomyolysis	☐ Yes	☐ No/Unknown
Chronic lung disease of prematurity/BPD	☐ Yes	☐ No/Unknown	Sepsis	☐ Yes	☐ No/Unknown
Congestive heart failure	☐ Yes	☐ No/Unknown	Seizures	☐ Yes	☐ No/Unknown
COPD exacerbation	☐ Yes	☐ No/Unknown	Stroke (CVA)	☐ Yes	☐ No/Unknown
Deep vein thrombosis (DVT)	☐ Yes	☐ No/Unknown	Toxic shock syndrome (TSS)	☐ Yes	☐ No/Unknown
Diabetic ketoacidosis	☐ Yes	☐ No/Unknown			

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 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. Additional Comments