

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

FORM APPROVED
OMB NO. 0920-0978



FluSurv-NET Case ID: <u>2 0 2 1</u>	COVID-NET Case ID: _____	RSV-NET Case ID: _____
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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:		<input type="checkbox"/> 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: ____ / ____ / ____
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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. State: _____	4. County: _____	5. Case Type: <input type="checkbox"/> Pediatric <input type="checkbox"/> Adult	6. Date of Birth: ____ / ____ / ____	7. Age: _____ <input type="checkbox"/> Years <input type="checkbox"/> Months (if < 1 yr) <input type="checkbox"/> Days (if < 1 month)	8. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
9. Race: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Multiracial <input type="checkbox"/> Not specified		10. Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Not Specified		11. Type of Insurance (select all that apply): <input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid/state assistance program <input type="checkbox"/> Military <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Incarcerated <input type="checkbox"/> Uninsured <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____		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. Hospital ID Where Patient Treated: _____							
13a. Admission Date: ____ / ____ / ____							
13b. Discharge Date: ____ / ____ / ____							

14. Was patient transferred from another hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.)

<input type="checkbox"/> Private residence	<input type="checkbox"/> Alcohol/Drug Abuse Treatment	<input type="checkbox"/> Hospice	<input type="checkbox"/> Psychiatric facility
<input type="checkbox"/> Private residence with services	<input type="checkbox"/> Hospitalized at birth	<input type="checkbox"/> Assisted living/Residential care	<input type="checkbox"/> Other long term care facility
<input type="checkbox"/> Homeless/shelter	<input type="checkbox"/> Rehabilitation facility	<input type="checkbox"/> LTACH	<input type="checkbox"/> Other, specify: _____
<input type="checkbox"/> Nursing home/Skilled nursing facility	<input type="checkbox"/> Corrections facility	<input type="checkbox"/> Group/Retirement home	<input type="checkbox"/> 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: <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"/> 2009 H1N1		<input type="checkbox"/> H1		<input type="checkbox"/> Flu B (no lineage)		<input type="checkbox"/> Flu B, Yamagata	
<input type="checkbox"/> H1, Unspecified		<input type="checkbox"/> H3		<input type="checkbox"/> Flu B, Victoria		<input type="checkbox"/> Flu A & B	
						<input type="checkbox"/> Flu A/B (not distinguished)	
1b. Specimen collection date: ____ / ____ / ____		1c. Specimen ID: _____		1d. Testing facility 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"/> 2009 H1N1		<input type="checkbox"/> H1		<input type="checkbox"/> Flu B (no lineage)		<input type="checkbox"/> Flu B, Yamagata	
<input type="checkbox"/> H1, Unspecified		<input type="checkbox"/> H3		<input type="checkbox"/> Flu B, Victoria		<input type="checkbox"/> Flu A & B	
						<input type="checkbox"/> Flu A/B (not distinguished)	
2b. Specimen collection date: ____ / ____ / ____		2c. Specimen ID: _____		2d. Testing facility 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"/> 2009 H1N1		<input type="checkbox"/> H1		<input type="checkbox"/> Flu B (no lineage)		<input type="checkbox"/> Flu B, Yamagata	
<input type="checkbox"/> H1, Unspecified		<input type="checkbox"/> H3		<input type="checkbox"/> Flu B, Victoria		<input type="checkbox"/> Flu A & B	
						<input type="checkbox"/> Flu A/B (not distinguished)	
3b. Specimen collection date: ____ / ____ / ____		3c. Specimen ID: _____		3d. Testing facility 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. ICU and Other Interventions

1. Was the patient admitted to an intensive care unit (ICU)?
1a. Date of 1st ICU Admission:
1b. Date of 1st ICU Discharge:
2. BiPAP or CPAP use?
3. High flow nasal cannula (e.g., Vapotherm)?
4. Invasive mechanical ventilation?
5. ECMO?
6. Vasopressor use?
7. Renal Replacement Therapy (RRT) or Dialysis?

F. Outcome

1. What was the outcome of the patient upon discharge?
2. If patient discharged alive, please indicate to where:
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)
Non-respiratory symptoms
Respiratory symptoms
2. Date of onset of acute respiratory symptoms (within 2 weeks before a positive influenza test):
3. Height
4. Weight
5. BMI
6. Smoker (tobacco):

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 (O₂) dependent
- Pulmonary fibrosis
- Restrictive lung disease
- Sarcoidosis
- Other, specify: _____

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, specify: _____

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, specify: _____

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, specify: _____

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, specify: _____

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 (P SCT)*), history of
- Transplant, solid organ (SOT), history of
- Other, specify: _____

*Current/in treatment or diagnosed in last 12 months

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, specify: _____

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, specify: _____

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, specify: _____

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)
- Oseltamivir (Tamiflu)
- Peramivir (Rapivab)
- Zanamivir (Relenza)
- Other, specify: _____
- Unknown

1b. Start date: ____ / ____ / ____ Unknown

1c. End date: ____ / ____ / ____ Unknown

2a. Treatment 2:

- Baloxavir marboxil (Xofluza)
- Oseltamivir (Tamiflu)
- Peramivir (Rapivab)
- Zanamivir (Relenza)
- Other, specify: _____
- Unknown

2b. Start date: ____ / ____ / ____ Unknown

2c. End date: ____ / ____ / ____ Unknown

