Influenza Hospitalization Surveillance Project Consent Form (for patient/proxy interview ONLY)

VERBAL CONSENT FORM

Hello. My name is _____ from the [state] Department of Public Health. May I speak to [patient's name /parent of (child's name)]? We are working with the Centers for Disease Control and Prevention and other health departments to learn more about influenza disease or the flu. To do this, we are talking to people who have been in the hospital with flu. We want to look at things that may affect their illness and whether they were vaccinated against flu.

Because you/your child [or NAME if speaking with proxy] were in the hospital for the flu beginning on [day admitted], I would like to ask you a few questions about whether you/your child [or NAME if speaking with proxy] received the flu vaccine this season. This will take about five minutes. Your participation is voluntary and if you choose to refuse it will not affect any medical care or benefits you receive. All of your responses will be kept confidential as much as the law allows. You may refuse to answer any questions and may stop at any time. This information will help [State/Local Health Department] and CDC better describe influenza-associated hospitalizations. Additionally, this information may help us improve vaccination recommendations for flu and better protect the public's health. There is no other benefit to you for answering these questions. There is also no risk to you. If you have any questions about the study, you may call [state contact] at the Department of Public Health at XXX-XXX-XXXX. Do you have any questions before I begin?

May I continue with this interview? □ Yes □ No [If YES, go to Appendix F]

If NO: Thank you for your time. Have a good day.

Name of person obtaining verbal consent: _____ Date: _____

Flesch-Kincaid: 7.7

Influenza Hospitalization Surveillance Project Case and Proxy Identifying Information

Patient Last name: _____First name: _____ Initial: _____

Date of birth: _____ /_____ /_____ Phone Number: _____

Proxy Last name: _____ First name: _____ Initial: _____

Phone Number: _____ Relationship to case patient _____

Note to collaborators: This is for your records only. Do not send this information to CDC. Keep this information in a secure locked place.