

2021-22 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form

FORM APPROVED
OMB NO. 0920-0978



FluSurv-NET Case ID: <u>2 1 2 2</u>	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:		<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: ____ / ____ / ____
---------------------------	--

C. Enrollment Information

1. Case Classification: <input type="checkbox"/> Prospective <input type="checkbox"/> Surveillance 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	
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: ____ / ____ / ____		13. Hospital ID Where Patient Treated: _____	
15. Where did the patient reside at the time of hospitalization? (Indicate TYPE of residence.) <input type="checkbox"/> Private residence <input type="checkbox"/> Private residence with services <input type="checkbox"/> Homeless/shelter <input type="checkbox"/> Nursing home/Skilled nursing facility		<input type="checkbox"/> Alcohol/Drug Abuse Treatment <input type="checkbox"/> Hospitalized at birth <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Corrections facility		<input type="checkbox"/> Hospice <input type="checkbox"/> Assisted living/Residential care <input type="checkbox"/> LTACH <input type="checkbox"/> Group/Retirement home		<input type="checkbox"/> Psychiatric facility <input type="checkbox"/> Other long term care facility <input type="checkbox"/> Other, specify: _____ <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"/> 2009 H1N1 <input type="checkbox"/> H1, Unspecified		<input type="checkbox"/> H1, Seasonal <input type="checkbox"/> H1 <input type="checkbox"/> H3		<input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B (no lineage) <input type="checkbox"/> Flu B, Victoria		<input type="checkbox"/> Flu B, Yamagata <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"/> 2009 H1N1 <input type="checkbox"/> H1, Unspecified		<input type="checkbox"/> H1, Seasonal <input type="checkbox"/> H1 <input type="checkbox"/> H3		<input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B (no lineage) <input type="checkbox"/> Flu B, Victoria		<input type="checkbox"/> Flu B, Yamagata <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"/> 2009 H1N1 <input type="checkbox"/> H1, Unspecified		<input type="checkbox"/> H1, Seasonal <input type="checkbox"/> H1 <input type="checkbox"/> H3		<input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B (no lineage) <input type="checkbox"/> Flu B, Victoria		<input type="checkbox"/> Flu B, Yamagata <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 25 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 (can add up to 3 ICU stays in database)

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:

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

3. Additional notes regarding discharge:

G. Admission and Patient History

1. Reason for admission:

<input type="checkbox"/> Influenza-related illness	<input type="checkbox"/> Inpatient surgery procedures	<input type="checkbox"/> Trauma	<input type="checkbox"/> Unknown
<input type="checkbox"/> OB/Labor and delivery admission	<input type="checkbox"/> Psychiatric admission needing acute medical care	<input type="checkbox"/> Other, specify: _____	

2. 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

<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Dysgeusia/decreased taste	<input type="checkbox"/> Headache	<input type="checkbox"/> Rash
<input type="checkbox"/> Altered mental status/confusion	<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Muscle aches/myalgias	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anosmia/decreased smell	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fever/chills	<input type="checkbox"/> Nausea/vomiting	

Respiratory symptoms

<input type="checkbox"/> Congested/runny nose	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath/respiratory distress	<input type="checkbox"/> URI/ILI
	<input type="checkbox"/> Hemoptysis/bloody sputum	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Wheezing

For cases < 2 years

<input type="checkbox"/> Apnea	<input type="checkbox"/> Decreased vocalization/stridor	<input type="checkbox"/> Hypothermia	<input type="checkbox"/> Lethargy
<input type="checkbox"/> Cyanosis	<input type="checkbox"/> Dehydration	<input type="checkbox"/> Inability to eat/poor feeding	

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

4. Height: _____ Inch Cm Unknown 5. Weight: _____ Lbs Kg Unknown

6. BMI (non-pregnant cases and cases ≥ 2 years only): _____ Unknown

7. Smoker (tobacco): Current Former No/Unknown 8. Alcohol abuse: Current Former No/Unknown

9. Substance Abuse: Current Former No/Unknown

10. Substance Abuse Type (current use only) check all that apply:

<input type="checkbox"/> IVDU	<input type="checkbox"/> Polysubstance abuse - not otherwise specified	<input type="checkbox"/> Opioids	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Methamphetamines	<input type="checkbox"/> Marijuana
<input type="checkbox"/> Other, specify: _____					<input type="checkbox"/> Unknown

11. Code status on admission: Full code DNR/DNI/CMO Unknown

H. Underlying Medical Conditions

1. Did the patient have any of the following pre-existing medical conditions? (Select all that apply):

 Yes No Unknown1a. Asthma/Reactive Airway Disease: Yes No/Unknown1b. 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

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*)

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

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
- 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)

1e. Cardiovascular Disease, continued:

- 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

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

1g. History of Guillain-Barre Syndrome: Yes No/Unknown1h. 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

*Current/in treatment or diagnosed in last 12 months

H. Underlying Medical Conditions (continued)

1i. Any Obesity? Yes No/Unknown
 Obese
 Severely/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)

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)

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)

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. Bacterial Pathogens - Sterile or respiratory site only (can record up to 5 pathogens in database)

1. Were any culture tests performed within 7 days of admission? (For patients that died in the hospital, include culture tests performed either 1) within 7 days of admission, 2) within 3 days prior to death, or 3) within 24 hours after death) Yes No Unknown

2. If yes, was there a positive culture for aspergillus, mucormycosis, or a bacterial pathogen? Yes No Unknown

2a. If yes, specify Pathogen 1: Aspergillus (fungus) Mucormycosis (fungus) _____ **2b. Date of culture:** _____ / _____ / _____

2c. Site where pathogen identified: Blood Bronchoalveolar lavage (BAL) Pleural fluid Cerebrospinal fluid (CSF)
 Sputum Endotracheal aspirate Other, specify: _____

2d. If Staphylococcus aureus, specify: Methicillin resistant (MRSA) Methicillin sensitive (MSSA) Sensitivity unknown

3a. If yes, specify Pathogen 2: Aspergillus (fungus) Mucormycosis (fungus) _____ **3b. Date of culture:** _____ / _____ / _____

3c. Site where pathogen identified: Blood Bronchoalveolar lavage (BAL) Pleural fluid Cerebrospinal fluid (CSF)
 Sputum Endotracheal aspirate Other, specify: _____

3d. If Staphylococcus aureus, specify: Methicillin resistant (MRSA) Methicillin sensitive (MSSA) Sensitivity unknown

J. Viral Pathogens

1. Was patient tested for any of the viral respiratory pathogens within 14 days prior to or within 7 days of admission?

(For patients that died in the hospital, include tests performed either 1) within 14 days prior to or within 7 days of admission, 2) within 3 days prior to death, or 3) within 24 hours after death)

 Yes No Unknown

1a. Respiratory syncytial virus/RSV	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	Date: _____ / _____ / _____
1b. Adenovirus	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	Date: _____ / _____ / _____
1c. Parainfluenza 1	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	Date: _____ / _____ / _____
1d. Parainfluenza 2	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	Date: _____ / _____ / _____
1e. Parainfluenza 3	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	Date: _____ / _____ / _____
1f. Parainfluenza 4	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	Date: _____ / _____ / _____
1g. Human metapneumovirus	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	Date: _____ / _____ / _____
1h. Rhinovirus/Enterovirus	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	Date: _____ / _____ / _____
1i. Coronavirus SARS-CoV-2	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	Date: _____ / _____ / _____
1j. Coronavirus, other: _____	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	Date: _____ / _____ / _____

K. 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:	<input type="checkbox"/> Baloxavir marboxil (Xofluza)	<input type="checkbox"/> Peramivir (Rapivab)	<input type="checkbox"/> Other, specify: _____
	<input type="checkbox"/> Oseltamivir (Tamiflu)	<input type="checkbox"/> Zanamivir (Relenza)	<input type="checkbox"/> Unknown
1b. Start date: _____ / _____ / _____	<input type="checkbox"/> Unknown	1c. End date: _____ / _____ / _____	<input type="checkbox"/> Unknown

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

2a. Treatment 2:	<input type="checkbox"/> Baloxavir marboxil (Xofluza)	<input type="checkbox"/> Peramivir (Rapivab)	<input type="checkbox"/> Other, specify: _____
	<input type="checkbox"/> Oseltamivir (Tamiflu)	<input type="checkbox"/> Zanamivir (Relenza)	<input type="checkbox"/> Unknown
2b. Start date: _____ / _____ / _____	<input type="checkbox"/> Unknown	2c. End date: _____ / _____ / _____	<input type="checkbox"/> Unknown

L. Chest Imaging – Based on radiology report only

1. Was a chest x-ray taken within 3 days of hospitalization?

 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:

<input type="checkbox"/> Report not available	<input type="checkbox"/> Cannot rule out pneumonia	<input type="checkbox"/> Lung infiltrate	<input type="checkbox"/> Empyema
<input type="checkbox"/> Air space density	<input type="checkbox"/> Consolidation	<input type="checkbox"/> Interstitial infiltrate	<input type="checkbox"/> Other
<input type="checkbox"/> Air space opacity	<input type="checkbox"/> Cavitation	<input type="checkbox"/> Lobar infiltrate	
<input type="checkbox"/> Bronchopneumonia/pneumonia	<input type="checkbox"/> ARDS (acute respiratory distress syndrome)	<input type="checkbox"/> Pleural Effusion	

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

N. ICD-10-CM codes Discharged Diagnoses (to be recorded in order of appearance)

ICD-10-CM codes not available:

- 1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

O. Pregnancy Information - To be completed for pregnant women only

1. Total # of pregnancies as of date of admission (Gravida, G): _____ Unknown
2. Total # of pregnancies that resulted in a live birth as of date of admission (Parity, P): _____ Unknown

3. Specify total # of fetuses for current pregnancy as of date of admission: 1 2 3 >3 Unknown

4. Specify gestational age in weeks as of date of admission: _____ Unknown
If gestational age in weeks unknown, specify trimester of pregnancy: 1st (0 to 13 6/7 weeks) 2nd (14 0/7 to 27 6/7 weeks) 3rd (28 0/7 to end) Unknown

5. Indicate pregnancy status at discharge or death: Still pregnant No longer pregnant Unknown

5a. If patient was pregnant on admission but no longer pregnant at discharge, indicate pregnancy outcome at discharge:
Healthy newborn
Ill newborn
Infant died
Miscarriage (intrauterine death at <20 weeks GA)
Stillbirth (intrauterine death at >=20 weeks GA)
Abortion
Unknown

5b. Pre-term live birth? (<37 weeks GA)
Yes Pre-term delivery, gestational age in weeks: _____
No
Unknown

5c. If no longer pregnant, indicate date of delivery or end of pregnancy: ____/____/____ Unknown

P. 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

Q. Additional Comments

Empty comment box