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

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

FORM APPROVED
OMB NO. 0920-0978

FluSurv-NET Case ID: 2122 | **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 distinguished)	☐ 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 distinguished)	☐ 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 distinguished)	☐ H3N2v	

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).

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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:

☐ 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. Reason for admission:

☐ Influenza-related illness
☐ Inpatient surgery procedures
☐ Trauma
☐ Unknown
☐ OB/Labor and delivery admission
☐ Psychiatric admission needing acute medical care
☐ 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

☐ Abdominal pain
☐ Altered mental status/confusion
☐ Anosmia/decreased smell
☐ Chest pain
☐ Conjunctivitis
☐ Diarrhea
☐ Dysgeusia/decreased taste
☐ Fatigue
☐ Fever/chills
☐ Headache
☐ Muscle aches/mylagias
☐ Nausea/vomiting
☐ Rash
☐ Seizures

Respiratory symptoms

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

For cases < 2 years

☐ Apnea
☐ Cyanosis
☐ Decreased vocalization/stridor
☐ Dehydration
☐ Hypothermia
☐ Inability to eat/poor feeding
☐ Lethargy

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:

☐ IVDU ☐ Polysubstance abuse - not otherwise specified ☐ Opioids ☐ Cocaine ☐ Methamphetamines ☐ Marijuana
☐ Other, specify: _____ ☐ Unknown

11. Code status on admission: ☐ Full code ☐ DNR/DNI/CMO ☐ 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):***

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

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)

☐ Yes ☐ No ☐ Unknown

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/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

**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
- ☐ 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

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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? ☐ Yes ☐ No ☐ Unknown

(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)

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 SARS-CoV-2	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____ / ____ / ____
1j. Coronavirus, other: ____	☐ Yes, positive	☐ Yes, negative	☐ 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: ☐ Baloxavir marboxil (Xofluza) ☐ Peramivir (Rapivab) ☐ Other, specify:____
☐ Oseltamivir (Tamiflu) ☐ Zanamivir (Relenza) ☐ Unknown

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

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

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

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

☐ 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
☐ Lobar infiltrate
☐ Pleural Effusion
☐ Empyema
☐ Other

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	☐ 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) or adults (MIS-A)	☐ 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			

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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

(If Healthy newborn, Ill newborn or Infant died, go to 5b.) →

☐ 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

Case ID: 2 1 2 2

Q. Additional Comments