Antiviral-Resistant Influenza Infection Case Report Form

Form Approved
OMB No. 0920-0004

FAX COMPLETED FORM TO: 404-639-3866 **CDC ID (*CDC use only*):** _______________

I. Specimen Information

State Lab Specimen ID _______________ Specimen Collection State _______________ Patient County of residence _______________ Patient State of residence _______________ Oseltamivir resistance ☐ Yes ☐ No ☐ Unk Zanamivir resistance ☐ Yes ☐ No ☐ Unk	**Reason for Antiviral Resistance Test:** ☐ Requested for Clinical Indication ☐ Surveillance ☐ Other _________________ **Date of Specimen Collection:** __ __/ __ __/ __ __ __ __	**Influenza type/subtype:** ☐ Influenza A ☐ H1N1 ☐ H3N2 ☐ Influenza B ☐ Unknown

II. Basic Information

If information is from patient interview please READ:: *I'm going to ask you for some information about yourself (your child) and your (the child's) illness. To help you remember, I am going to tell you the date that your nose/ throat swab was taken to test for flu (*use specimen collection date in section I*). Please feel free to look at a calendar to help you remember dates. I can wait until you find one.*

Age: __ __ ☐ yrs ☐ months **Sex:** ☐ Male ☐ Female **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	**Race:** ☐ American Indian/ Alaska Native ☐ Asian or Pacific Islander ☐ Black or African American ☐ White ☐ Other __________ ☐ Unknown	**Illness History:** Date of illness onset: __ __/ __ __/ __ __ __ __ Hospitalized for illness? ☐Yes ☐No ☐Unknown	**Patient Outcome:** ☐ At Home ☐ At Extended Care Facility ☐ Currently Hospitalized ☐ Dead (Was it influenza-related? ☐Yes ☐ No ☐ Unknown) ☐ Unknown

III. Pre-existing Medical Conditions

Did a doctor ever tell you that you (your child) had any of the following conditions? (Check all that apply)

☐ No underlying conditions
☐ Diabetes Mellitus
☐ Chronic kidney disease
☐ Asthma
☐ Chronic lung disease (non-asthma), specify_______
☐ Neurologic/neuromuscular disease
☐ Immunosuppressive condition **(complete section below)**
☐ Chronic Heart Disease, specify: ___________________
☐ Chronic Liver Disease, specify: ___________________
☐ Morbid obesity: Height _______ Weight _______
☐ Other Condition, specify: ___________________

If female aged ≥16 years, were you pregnant at time of specimen collection: ☐ Yes ☐ No ☐ Unknown Trimester ______

Immunosuppression Details (check all that apply)

	☐ Solid Tumor Malignancy:	☐ Hematologic Malignancy:	☐ Receipt of Stem Cell Transplant	☐ Receipt of Solid Organ Transplant	☐ Autoimmune Disorder
Specify type(s)					
☐ Other condition (Lupus, Rheumatoid Arthritis, Crohns, etc) Specify Type (s):					☐ HIV/AIDS

IV. Hospitalized Patient Information (skip to section V if patients is not hospitalized)

Date of hospital admission: __ __/ __ __/ __ __ __ __ Date of hospital discharge: __ __/ __ __/ __ __ __ __	Where was the patient discharged to? ☐ Other hospital ☐ Home ☐ Hospice ☐ Rehabilitation facility ☐ Long term care facility ☐ Other

Reason for Hospital Admission: ☐ Respiratory Illness ☐ Other, specify:

During hospitalization, was patient in Intensive Care Unit? ☐ Yes ☐ No ☐ Unknown

Public reporting burden of this collection of information is estimated to average 30 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 Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0004).

V. Influenza Antiviral Medication History

Received influenza antiviral medications including oseltamivir (Tamiflu®) or zanamivir (Relenza®)?
☐ Yes ☐ No **(skip to section VI)** ☐ Unknown **(skip to section VI)**
If yes, Please check all below that apply:

☐ **Oseltamivir (Tamiflu)**
Dose: ☐ 75mg ☐ Other _______ Frequency: ☐ QD ☐ BID ☐ Other _____ Indication: ☐ Treatment ☐ Prevention
Location: ☐ Outpatient ☐ Inpatient Start Date: __ __/ __ __/ __ __ __ __ End Date: __ __/ __ __/ __ __ __ __

☐ **Zanamivir (Relenza)**
Dose: ☐ 10mg ☐ Other _______ Route: ☐ Inhaled ☐ IV (experimental) Frequency: ☐ QD ☐ BID ☐ Other _____
Indication: ☐ Treatment ☐ Prevention Location: ☐ Outpatient ☐ Inpatient
Start Date: __ __/ __ __/ __ __ __ __ End Date: __ __/ __ __/ __ __ __ __

☐ **Additional/other Agent**
Name: _______________________
Dose: _______________________ Route: ☐ Oral ☐ IV ☐ Inhaled Frequency: ☐ BID ☐ Other _______
Indication: ☐ Treatment ☐ Prevention Location: ☐ Outpatient ☐ Inpatient
Start Date: __ __/ __ __/ __ __ __ __ End Date: __ __/ __ __/ __ __ __ __

Patient finished all of the pills (or suspension)? ☐ Yes ☐ No ☐ Unknown

Information on antiviral treatment is from (check all that apply)
☐ inpatient medical record ☐ outpatient medical record ☐ dispensing pharmacy ☐ self-report

Comments about antiviral therapy: (e.g. other courses of antiviral treatment, reasons for poor compliance, etc.)

VI. Influenza Vaccine History

Did you (your child) receive the influenza vaccine this year? ☐ Yes ☐ No ☐ Unknown

VII. Clinical Illness [Read to patient: *I am going to ask you some questions about your (your child's) illness. Please feel free to look at the calendar to help you remember.*]

1. Did you (your child) have a fever or feel feverish when you (he/she) had flu? ☐ Yes ☐ No (skip to Q2) ☐ DK (skip to Q2)
   1a. How many days did you (your child) have fever? ______ day(s)
   1b. Did you take your (your child's) temperature? ☐ Yes ☐ No (skip to Q2) ☐ DK (skip to Q2)
   1c. What was the highest temperature that you recorded? __________
6. On what date did you first seek medical care for the flu illness? __ __ / __ __ / __ __ __ __

VIII. Transmission History [Read to patient: *I'm going to ask some questions about others in your home who may have been ill and travel.]*

1. At the time you (your child) became ill, where did you reside?
   ☐ Single Family House (1 housing unit in building)
   ☐ University Dorm or boarding school
   ☐ Multi-Family Housing (> 1 unit in building)
   ☐ Other, specify: ______________________________
   ☐ Facility (hospital, long term care, nursing home, jail, etc)
2. During the week before illness, did anyone else in the household have flu or a respiratory illness? ☐ Yes ☐ No ☐ Unknown
   If yes, how many? ________
   If Yes, Did anyone else other than you in the household get a diagnosis of flu? ☐ Yes ☐ No ☐ Unknown
   If yes, how many? ________
3. During the week before illness, did anyone else in the household receive any antiviral medications? ☐ Yes (☐ for treatment ☐ for prevention) ☐ No ☐ Unknown
   If yes, What was the name of the antiviral agent? ☐ Tamiflu ☐Relenza ☐Unknown ☐Other specify______
4. Did you travel outside of your typical residence area during the 7 days prior to illness? ☐ Yes ☐ No ☐ Unknown
   If yes, Where did you travel to? Country__________ state______ city/town_____________
   Dates of travel? __ __/ __ __/ __ __ __ __ to __ __/ __ __/__ __ __ __

If the patient is a child, university student or living in a facility (e.g. LTCF), ask the following questions, if not, skip to the next section.

5. Were others at your (your child's) school/residency also sick at the same time as your (the child's) flu illness?
   ☐ Yes ☐ No ☐ DK **If yes**, where do you (your child) go to school/ reside? _________________________________

IX. Additional Comments			
Sender Information			
First Name:	Last Name:		Date of Survey Completion: __ __/ __ __/ __ __ __ __
Institution Name:		Email Address:	Telephone Number: