

Influenza-Associated Pediatric Mortality Case Report Form

Form Approved
OMB No. 0920-0004

STATE USE ONLY – DO NOT SEND INFORMATION IN THIS SECTION TO CDC

Last Name: _____ First Name: _____ County: _____

Address: _____ City: _____ State, Zip: _____

Patient Demographics

1. State:	2. County:	3. State ID:	4. CDC ID:
5. Age: _____ <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	6. Date of birth: _____/_____/_____ <div style="text-align: center;">MM DD YYYY</div>		7a. Is sex known? <input type="checkbox"/> Yes <input type="checkbox"/> No 7b. Sex: <input type="radio"/> Male <input type="radio"/> Female
8a. Is ethnicity known? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8b. Ethnicity: <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino			
9a. Is race known? <input type="checkbox"/> Yes <input type="checkbox"/> No			
9b. Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native			

Death Information

10. Date of illness onset: _____/_____/_____ <div style="text-align: center;">MM DD YYYY</div>	11. Date of death: _____/_____/_____ <div style="text-align: center;">MM DD YYYY</div>	12. Was an autopsy performed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
13 a. Did cardiac/respiratory arrest occur outside the hospital? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
13 b. Location of death: <input type="radio"/> Outside the Hospital (e.g. home or in transit to hospital) <input type="radio"/> Emergency Dept (ED) <input type="radio"/> Inpatient ward <input type="radio"/> ICU <input type="radio"/> Other (specify): _____		
13 c. If the death occurred in the hospital, what was the date of admission? _____/_____/_____ <div style="text-align: center;">MM DD YYYY</div>		

CDC Laboratory Specimens

14 a. Were pathology specimens sent to CDC's Infectious Diseases Pathology Branch? Yes No Unknown
 Please provide the lab ID No. if known _____

14 b. Were influenza isolates or original clinical material sent to CDC's Influenza Division? Yes No Unknown
 Please provide the lab ID No. if known _____

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).

Culture confirmation of bacterial pathogens from NON-STERILE SITES

16 d. Were other **respiratory** specimens collected for bacterial culture (e.g., sputum, ET tube aspirate)? O Yes O No O Unknown

16 e. If yes, please indicate the site from which the specimen was obtained and the result. *If more than one specimen type is positive and more than one organism is identified please indicate the organism cultured from each specimen type in the comments section.*

Specimen Type	Collection Date	Result
<input type="checkbox"/> Sputum	Date ___/___/___	O Positive O Negative O Unknown
<input type="checkbox"/> ET tube	Date ___/___/___	O Positive O Negative O Unknown
<input type="checkbox"/> Other _____	Date ___/___/___	O Positive O Negative O Unknown
<input type="checkbox"/> Unknown		

16 f. If positive, please check the organism cultured.

- | | | |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> <i>Streptococcus pneumoniae</i> | <input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin sensitive (MSSA) | <input type="checkbox"/> <i>Haemophilus influenzae</i> not-type b |
| <input type="checkbox"/> Group A <i>Streptococcus</i> | <input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin resistant (MRSA) | <input type="checkbox"/> <i>Haemophilus influenzae</i> type b |
| <input type="checkbox"/> Other bacteria: _____ | <input type="checkbox"/> <i>Staphylococcus aureus</i> , sensitivity not done | <input type="checkbox"/> <i>Pseudomonas aeruginosa</i> |

(If reporting another viral co-infection please do so in section 18 Clinical Diagnosis and Complications)

Pathology confirmation of bacterial pathogens

16 g. Was a specimen (e.g., fixed lung tissue) collected from an autopsy for testing of bacterial pathogens by a local or state pathologist? *(If pathology results are available from CDC it is not necessary to input those results here, however please make sure to complete section 14 "CDC Laboratory Specimens")* O Yes O No O Unknown

If yes please indicate the results of these tests in the comments section at the end of the form.

Medical Care

17. Was the patient placed on mechanical ventilation? O Yes O No O Unknown

Clinical Diagnoses and Complications

18 a. Did complications occur during the acute illness? Yes No Unknown

18 b. **If yes**, check all complications that occurred during the acute illness:

- | | | | |
|------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------|
| <input type="checkbox"/> Pneumonia (Chest X-Ray confirmed) | <input type="checkbox"/> Acute Respiratory Disease Syndrome (ARDS) | <input type="checkbox"/> Croup | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bronchiolitis | <input type="checkbox"/> Encephalopathy/encephalitis | <input type="checkbox"/> Reye syndrome | <input type="checkbox"/> Shock |
| <input type="checkbox"/> Sepsis | <input type="checkbox"/> Hemorrhagic pneumonia/pneumonitis | <input type="checkbox"/> Cardiomyopathy/myocarditis | |
| <input type="checkbox"/> Another viral co-infection: _____ | | <input type="checkbox"/> Other: _____ | |

19 a. Did the child have any medical conditions that existed before the start of the acute illness? Yes No Unknown

19 b. **If yes**, check all medical conditions that existed before the start of the acute illness:

- | | | | | |
|----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------------|
| <input type="checkbox"/> Moderate to severe developmental delay | <input type="checkbox"/> Hemoglobinopathy (e.g. sickle cell disease) | <input type="checkbox"/> Asthma/ reactive airway disease | | |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> History of febrile seizures | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Cystic fibrosis | |
| <input type="checkbox"/> Cardiac disease/congenital heart disease (specify) _____ | <input type="checkbox"/> Renal disease (specify) _____ | <input type="checkbox"/> Skin or soft tissue infection (SSTI) | | |
| <input type="checkbox"/> Chromosomal Abnormality/Genetic Syndrome (specify) _____ | <input type="checkbox"/> Mitochondrial Disorder (specify) _____ | | | |
| <input type="checkbox"/> Chronic pulmonary disease (specify) _____ | <input type="checkbox"/> Immunosuppressive condition (specify) _____ | | | |
| <input type="checkbox"/> Cancer (diagnosis and/or treatment began in previous 12 months) (specify) _____ | <input type="checkbox"/> Endocrine disorder (specify) _____ | <input type="checkbox"/> Obesity | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Premature at birth (specify gestational age) _____ weeks |
| <input type="checkbox"/> Neuromuscular disorder (e.g. muscular dystrophy) (specify) _____ | <input type="checkbox"/> Other Neurological disorder (specify) _____ | | | |
| <input type="checkbox"/> Pregnant (specify gestational age) _____ weeks | <input type="checkbox"/> Other (specify) _____ | | | |

Medication and Therapy History

20 a. Was the patient receiving any of the following therapies *prior* to illness onset? (if yes, check all that apply)

- | | | | |
|-----------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | |
| <input type="checkbox"/> Antiviral Prophylaxis | <input type="checkbox"/> Chronic aspirin therapy | <input type="checkbox"/> Chemotherapy or radiation therapy | <input type="checkbox"/> Steroids by mouth or injection |
| <input type="checkbox"/> Other immunosuppressive therapy: _____ | | | |

20 b. Did the patient receive any of the following *after* illness onset? (if yes, check all that apply)

- | | | | |
|-----------------------------------------------------------|----------------------------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | |
| <input type="checkbox"/> Antibiotic therapy specify _____ | <input type="checkbox"/> Antiviral therapy specify _____ | | |

Influenza Vaccine History

21. Did the patient receive any influenza vaccine during the current season (before illness) Yes No Unknown

22. **If YES***, please specify the influenza vaccine received before illness onset:

Inactivated influenza vaccine (IIV3) *[injected]*
 Quadrivalent inactivated influenza vaccine (IIV4) *[injected]*
 Live-attenuated influenza vaccine (LAIV4) *[nasal spray]*
 Unknown

23. **If YES***, how many doses did the patient receive and what was the timing of each dose? (Enter vaccination dates if available)

O 1 dose <14 days prior to illness onset
ONLY ≥14 days prior to illness onset

Date dose given: ____ / ____ / ____
MM DD YYYY

O 2 doses 2nd dose given <14 days prior to onset
 2nd dose given ≥14 days prior to onset

Date of 1st dose: ____ / ____ / ____
MM DD YYYY

Date of 2nd dose: ____ / ____ / ____
MM DD YYYY

23b. IF the patient received two doses of influenza vaccine during the current season, please specify the SECOND influenza vaccine received before illness onset:

Inactivated influenza vaccine (IIV3) *[injected]*
 Quadrivalent inactivated influenza vaccine (IIV4) *[injected]*
 Live-attenuated influenza vaccine (LAIV4) *[nasal spray]*
 Unknown

24. Did the patient receive any influenza vaccine in previous seasons? Yes No Unknown

24 a. If YES, and the patient was ≤ 8 years of age at time of death, have they received a total of 2 or more doses of influenza vaccine (does need not have been received in the same season or consecutive seasons)? Yes No Unknown

25a. Were immunization records or information about influenza vaccination available for this case? Yes No Unknown

25b. If yes, please check all sources of information on the patient's influenza vaccination history that were reviewed (please check all that apply).

Patient's immunization record Medical records Coroner's report
 Immunization information system (registry) Parent report News/media report
 Other (specify): _____

Submitted By: _____ Date: ____ / ____ / ____
Phone No.: (____) _____ - _____
MM DD YYYY
E-mail Address: _____

Case Investigation Closed: Yes No