

# 2022-23 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form

FORM APPROVED  
OMB NO. 0920-0978



<b>FluSurv-NET Case ID:</b> 2 2 2 3	<b>COVID-NET Case ID:</b>	<b>RSV-NET Case ID:</b>
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### 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: ____ / ____ / ____
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### C. Enrollment Information

<b>1. Case Classification:</b> <input type="checkbox"/> Prospective <input type="checkbox"/> Surveillance Discharge Audit	<b>2. State:</b>	<b>3. County:</b>	<b>4. Case Type:</b> <input type="checkbox"/> Pediatric <input type="checkbox"/> Adult	<b>5. Date of Birth:</b> ____ / ____ / ____	<b>6. Age:</b> ____ <input type="checkbox"/> Years <input type="checkbox"/> Months (if < 1 yr) <input type="checkbox"/> Days (if < 1 month)	<b>7. Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>8. Race</b> (select all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Multiracial, not otherwise specified <input type="checkbox"/> Not specified	<b>9. Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Not Specified	<b>11. Type of Insurance</b> (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: _____		<b>12. Pregnant?</b> (15-49 years of age only): <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown <input type="checkbox"/> Not applicable (male)		
<b>10. Was patient discharged from any hospital within 1 week prior to the current admission date?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>13. Hospital ID Where Patient Treated:</b> _____ <b>13a. Admission Date:</b> ____ / ____ / ____ <b>13b. Discharge Date:</b> ____ / ____ / ____				
<b>14. Was patient transferred from another hospital?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>14a. Transfer Hospital ID:</b> _____	<b>14b. Transfer Hospital Admission Date:</b> ____ / ____ / ____	<b>14c. Transfer Date:</b> ____ / ____ / ____			
<b>15. Where did the patient reside at the time of hospitalization? (Indicate TYPE of residence.)</b> <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)

<b>1. Test 1:</b> <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
<b>1a. Result:</b> <input type="checkbox"/> Flu A (no subtype) <input type="checkbox"/> H1, Seasonal <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B, Yamagata <input type="checkbox"/> Unknown Type <input type="checkbox"/> Other, please specify: <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H1 <input type="checkbox"/> Flu B (no lineage) <input type="checkbox"/> Flu A & B <input type="checkbox"/> Negative <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> H3 <input type="checkbox"/> Flu B, Victoria <input type="checkbox"/> Flu A/B (not distinguished) <input type="checkbox"/> H3N2v
<b>1b. Specimen collection date:</b> ____ / ____ / ____ <b>1c. Specimen ID:</b> _____ <b>1d. Testing facility ID:</b> _____
<b>2. Test 2:</b> <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
<b>2a. Result:</b> <input type="checkbox"/> Flu A (no subtype) <input type="checkbox"/> H1, Seasonal <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B, Yamagata <input type="checkbox"/> Unknown Type <input type="checkbox"/> Other, please specify: <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H1 <input type="checkbox"/> Flu B (no lineage) <input type="checkbox"/> Flu A & B <input type="checkbox"/> Negative <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> H3 <input type="checkbox"/> Flu B, Victoria <input type="checkbox"/> Flu A/B (not distinguished) <input type="checkbox"/> H3N2v
<b>2b. Specimen collection date:</b> ____ / ____ / ____ <b>2c. Specimen ID:</b> _____ <b>2d. Testing facility ID:</b> _____
<b>3. Test 3:</b> <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
<b>3a. Result:</b> <input type="checkbox"/> Flu A (no subtype) <input type="checkbox"/> H1, Seasonal <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B, Yamagata <input type="checkbox"/> Unknown Type <input type="checkbox"/> Other, please specify: <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H1 <input type="checkbox"/> Flu B (no lineage) <input type="checkbox"/> Flu A & B <input type="checkbox"/> Negative <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> H3 <input type="checkbox"/> Flu B, Victoria <input type="checkbox"/> Flu A/B (not distinguished) <input type="checkbox"/> H3N2v
<b>3b. Specimen collection date:</b> ____ / ____ / ____ <b>3c. Specimen ID:</b> _____ <b>3d. Testing facility ID:</b> _____

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**

1. Was the patient admitted to an intensive care unit (ICU)?  Yes  No  Unknown  
 1a. Date of 1<sup>st</sup> ICU Admission: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Unknown    1b. Date of 1<sup>st</sup> 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  Unknown

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<sub>2</sub>) 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/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

**H. Underlying Medical Conditions (continued)**

- 1i. Any Obesity:**  Yes  No/Unknown  
 Obese  
 Severely/morbidly obese (ADULTS ONLY)
- 1j. Post-Partum (two weeks or less):**  Yes  No/Unknown
- 1k. 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)
- 1l. 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)

- 1m. 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*)
- 1n. Hypertension:**  Yes  No/Unknown
- 1o. Mental Health Conditions:**  Yes  No/Unknown  
 Anxiety disorder  
 Bipolar disorder  
 Depression  
 Schizophrenia spectrum disorder
- 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 - (can add additional culture results to the study database) - Sterile or respiratory site only**

1. Were any culture tests performed within 3 days prior to or 3 days following admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>Culture 1</b>		
2a. If yes, what is the specimen source? <input type="checkbox"/> Blood <input type="checkbox"/> Bronchoalveolar lavage (BAL) <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Cerebrospinal fluid (CSF) <input type="checkbox"/> Sputum <input type="checkbox"/> Endotracheal aspirate <input type="checkbox"/> Other, specify: _____		
2b. Date of specimen collection for culture _____/_____/_____	2c. Result of culture: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	2d. If positive, what pathogen was identified? <input type="checkbox"/> Bacteria, specify: _____ <input type="checkbox"/> Aspergillus (fungus) <input type="checkbox"/> Mucormycosis (fungus)
2e. If <i>Staphylococcus aureus</i> , specify: <input type="checkbox"/> Methicillin resistant (MRSA) <input type="checkbox"/> Methicillin sensitive (MSSA) <input type="checkbox"/> Sensitivity unknown		
<b>Culture 2</b>		
3a. If yes, what is the specimen source? <input type="checkbox"/> Blood <input type="checkbox"/> Bronchoalveolar lavage (BAL) <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Cerebrospinal fluid (CSF) <input type="checkbox"/> Sputum <input type="checkbox"/> Endotracheal aspirate <input type="checkbox"/> Other, specify: _____		
3b. Date of specimen collection for culture _____/_____/_____	3c. Result of culture: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	3d. If positive, what pathogen was identified? <input type="checkbox"/> Bacteria, specify: _____ <input type="checkbox"/> Aspergillus (fungus) <input type="checkbox"/> Mucormycosis (fungus)
3e. If <i>Staphylococcus aureus</i> , specify: <input type="checkbox"/> Methicillin resistant (MRSA) <input type="checkbox"/> Methicillin sensitive (MSSA) <input type="checkbox"/> Sensitivity unknown		

**J. Viral Pathogens**

**1. Was patient tested for any of the following viral respiratory pathogens within 14 days prior to admission or ≤3 days after admission?**  Yes  No  Unknown

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

**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

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

**2b. Start 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:**

<input type="checkbox"/> Report not available	<input type="checkbox"/> Cannot rule out pneumonia	<input type="checkbox"/> Lung infiltrate	<input type="checkbox"/> Emphyema
<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	Guillain-Barre syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown
Acute liver failure	<input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	Hemophagocytic syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown
Acute myocardial infarction	<input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	Invasive pulmonary aspergillosis	<input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown
Acute myocarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	Kawasaki disease	<input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown
Acute renal failure/acute kidney injury	<input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	Mucormycosis	<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		
Disseminated intravascular coagulation (DIC)	<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**

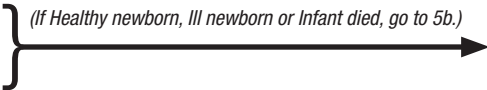
- |  |   |
|--|---|
| <b>1. Total # of pregnancies as of date of admission (Gravida, G):</b><br>_____ <input type="checkbox"/> Unknown | <b>2. Total # of pregnancies that resulted in a live birth as of date of admission (Parity, P):</b><br>_____ <input type="checkbox"/> Unknown |
|--|---|

**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**