

## 2023-24 Influenza Hospitalization Surveillance Network (FluSurv-NET) Case Report Form



FORM APPROVED  
OMB NO. 0920-0978

FluSurv-NET Case ID: _____	COVID-NET Case ID: _____	RSV-NET Case ID: _____
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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:			
Pharmacy of Record:		Pharmacy Phone:		Pharmacy Fax:			
Pharmacy Address:							
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"/> 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 (select all that apply):</b> <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 (select all that apply):</b> <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? (15-49 years of age only):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown <input type="checkbox"/> Not applicable (male/pregnant outside of applicable age range)		
<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"/> Substance abuse treatment center	<input type="checkbox"/> Hospice	<input type="checkbox"/> Psychiatric facility			
<input type="checkbox"/> Private residence with services	<input type="checkbox"/> Hospitalized at birth	<input type="checkbox"/> Assisted living/Residential care	<input type="checkbox"/> Other long term care facility			
<input type="checkbox"/> Homeless/Shelter/Temporary housing	<input type="checkbox"/> Rehabilitation facility	<input type="checkbox"/> LTACH	<input type="checkbox"/> Other, specify: _____			
<input type="checkbox"/> Nursing home/Skilled nursing facility	<input type="checkbox"/> Corrections facility	<input type="checkbox"/> Group/Retirement home	<input type="checkbox"/> Unknown			

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).

Case ID: \_\_\_\_\_

**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"/> 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) <input type="checkbox"/> Unknown Type <input type="checkbox"/> Negative <input type="checkbox"/> H3N2v <input type="checkbox"/> Other, please specify: _____
<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"/> 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) <input type="checkbox"/> Unknown Type <input type="checkbox"/> Negative <input type="checkbox"/> H3N2v <input type="checkbox"/> Other, please specify: _____
<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"/> 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) <input type="checkbox"/> Unknown Type <input type="checkbox"/> Negative <input type="checkbox"/> H3N2v <input type="checkbox"/> Other, please specify: _____
<b>3b. Specimen collection date:</b> ____/____/____	<b>3c. Specimen ID:</b> _____	<b>3d. Testing facility ID:</b> _____	

**E. Other Interventions and ICU**

<b>1. BiPAP or CPAP?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>2. High flow nasal cannula (e.g., Vapotherm)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>3. Invasive mechanical ventilation?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>4. ECMO?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>5. Supplemental Oxygen?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>6. Renal Replacement Therapy (RRT) or Dialysis?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Includes Peritoneal Dialysis (PD), Hemodialysis (HD), Continuous Venovenous Hemofiltration (CVVH), Continuous Venovenous Hemodialysis (CVVHD), and Slow Continuous Ultrafiltration (SCUF)
<b>7. Was the patient admitted to an intensive care unit (ICU)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>7a. Date of 1<sup>st</sup> ICU Admission:</b> ____/____/____ <input type="checkbox"/> Unknown	<b>7b. Date of 1<sup>st</sup> ICU Discharge:</b> ____/____/____ <input type="checkbox"/> Unknown

**F. Outcome**

<b>1. What was the outcome of the patient upon discharge?</b> <input type="checkbox"/> Alive <input type="checkbox"/> Died during hospitalization <input type="checkbox"/> Unknown
<b>2. If patient discharged alive, please indicate to where:</b> <input type="checkbox"/> Private residence <input type="checkbox"/> Private residence with services <input type="checkbox"/> Homeless/Shelter/ <b>Temporary housing</b> <input type="checkbox"/> Nursing home/Skilled nursing facility <input type="checkbox"/> <b>Substance abuse treatment center</b> <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"/> Against medical advice (AMA) <input type="checkbox"/> Discharged to another hospital <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown

**3. Additional notes regarding discharge:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**G. Admission and Patient History**

**1. Reason for admission:**

- Influenza-related illness       Psychiatric admission needing acute medical care       Other, specify: \_\_\_\_\_  
 OB/Labor and delivery admission       **Newborn/Hospitalized at birth**       Unknown  
 Inpatient surgery/procedures       Trauma

**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       Anosmia/Decreased smell       Diarrhea       Fever/chills       Nausea/vomiting  
 Altered mental status/ confusion       Chest pain/**tightness**       Dysgeusia/Decreased taste       Headache       Rash  
 Conjunctivitis       Fatigue       Muscle aches/myalgias       Seizures

**Respiratory symptoms**

- Chest congestion**       Cough       Shortness of breath/ respiratory distress       URI/ILI  
 Congested/runny nose       Hemoptysis/bloody sputum       Sore throat       Wheezing

**For cases < 12 years**

- Apnea       Hypothermia       Lethargy/**decreased activity**       **Stridor/decreased vocalization**  
 Cyanosis       Inability to eat/poor feeding       **Nasal flaring/grunting/retractions**       **Tachypnea/increased work of breathing**  
 **Dehydration/decreased urine output**       **Irritability/fussiness/excess crying**

**3. Date of onset of acute respiratory symptoms (within 2 weeks before a positive 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. Environmental tobacco smoke exposure (for pediatric patients < 12 years):**

- Yes**       **No**       **Unknown**

**9. Alcohol abuse:**

- Current       Former       No/Unknown

**10. Substance abuse:**

- Current       Former       No/Unknown

**11. Substance Abuse Type (current use only) (Select all that apply):**

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

**12. 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 (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)
- 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

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

**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

**1i. 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)

**1j. Any Obesity:**  Yes  No/Unknown

- Obese
- Severely/morbidly obese (ADULTS ONLY)

**1k. Post-partum (two weeks or less):**  Yes  No/Unknown

**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. Mental Health Conditions:**  Yes  No/Unknown

- Bipolar disorder
- Depression
- Schizophrenia spectrum disorder

**1o. Hypertension (HTN):**  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 (gestational 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**

Were any culture tests performed within 3 days prior to or 3 days following admission?  Yes  No  Unknown

**Specimen 1**

1a. If yes, what is the specimen source?

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Blood   | <input type="checkbox"/> Cerebrospinal fluid (CSF)             | <input type="checkbox"/> Pleural fluid | <input type="checkbox"/> Wound - Group A Streptococcus (only) |
| <input type="checkbox"/> Bone/joint aspirate                                   | <input type="checkbox"/> Endotracheal/tracheal aspirate        | <input type="checkbox"/> Sputum        | <input type="checkbox"/> Other, specify: _____                |
| <input type="checkbox"/> Bronchoalveolar lavage (BAL), bronchial aspirate/wash | <input type="checkbox"/> Peritoneal or abdominal fluid/ascites |  |   |

1b. Date of specimen collection for culture

\_\_\_\_/\_\_\_\_/\_\_\_\_

1c. Result of culture:

- Positive  
 Negative  
 Unknown

1d. If positive, what pathogen was identified?

- Bacteria, specify:  
 Aspergillus (fungus)  
 Mucormycosis (fungus)

1e. If Staphylococcus aureus, specify:

- Methicillin resistant (MRSA)  
 Methicillin sensitive (MSSA)  
 Sensitivity unknown

**Specimen 2**

2a. If yes, what is the specimen source?

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Blood   | <input type="checkbox"/> Cerebrospinal fluid (CSF)             | <input type="checkbox"/> Pleural fluid | <input type="checkbox"/> Wound - Group A Streptococcus (only) |
| <input type="checkbox"/> Bone/joint aspirate                                   | <input type="checkbox"/> Endotracheal/tracheal aspirate        | <input type="checkbox"/> Sputum        | <input type="checkbox"/> Other, specify: _____                |
| <input type="checkbox"/> Bronchoalveolar lavage (BAL), bronchial aspirate/wash | <input type="checkbox"/> Peritoneal or abdominal fluid/ascites |  |   |

2b. Date of specimen collection for culture

\_\_\_\_/\_\_\_\_/\_\_\_\_

2c. Result of culture:

- Positive  
 Negative  
 Unknown

2d. If positive, what pathogen was identified?

- Bacteria, specify:  
 Aspergillus (fungus)  
 Mucormycosis (fungus)

2e. If Staphylococcus aureus, specify:

- Methicillin resistant (MRSA)  
 Methicillin sensitive (MSSA)  
 Sensitivity unknown

**Specimen 3**

3a. If yes, what is the specimen source?

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Blood   | <input type="checkbox"/> Cerebrospinal fluid (CSF)             | <input type="checkbox"/> Pleural fluid | <input type="checkbox"/> Wound - Group A Streptococcus (only) |
| <input type="checkbox"/> Bone/joint aspirate                                   | <input type="checkbox"/> Endotracheal/tracheal aspirate        | <input type="checkbox"/> Sputum        | <input type="checkbox"/> Other, specify: _____                |
| <input type="checkbox"/> Bronchoalveolar lavage (BAL), bronchial aspirate/wash | <input type="checkbox"/> Peritoneal or abdominal fluid/ascites |  |   |

3b. Date of specimen collection for culture

\_\_\_\_/\_\_\_\_/\_\_\_\_

3c. Result of culture:

- Positive  
 Negative  
 Unknown

3d. If positive, what pathogen was identified?

- Bacteria, specify:  
 Aspergillus (fungus)  
 Mucormycosis (fungus)

3e. If Staphylococcus aureus, specify:

- Methicillin resistant (MRSA)  
 Methicillin sensitive (MSSA)  
 Sensitivity unknown

**Specimen 4**

4a. If yes, what is the specimen source?

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Blood   | <input type="checkbox"/> Cerebrospinal fluid (CSF)             | <input type="checkbox"/> Pleural fluid | <input type="checkbox"/> Wound - Group A Streptococcus (only) |
| <input type="checkbox"/> Bone/joint aspirate                                   | <input type="checkbox"/> Endotracheal/tracheal aspirate        | <input type="checkbox"/> Sputum        | <input type="checkbox"/> Other, specify: _____                |
| <input type="checkbox"/> Bronchoalveolar lavage (BAL), bronchial aspirate/wash | <input type="checkbox"/> Peritoneal or abdominal fluid/ascites |  |   |

4b. Date of specimen collection for culture

\_\_\_\_/\_\_\_\_/\_\_\_\_

4c. Result of culture:

- Positive  
 Negative  
 Unknown

4d. If positive, what pathogen was identified?

- Bacteria, specify:  
 Aspergillus (fungus)  
 Mucormycosis (fungus)

4e. If Staphylococcus aureus, specify:

- Methicillin resistant (MRSA)  
 Methicillin sensitive (MSSA)  
 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

1a. 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. <b>Coronavirus 229E</b>	<input type="checkbox"/> <b>Yes, positive</b>	<input type="checkbox"/> <b>Yes, negative</b>	<input type="checkbox"/> <b>Not tested/Unknown</b>	Date: ____/____/____
1j. <b>Coronavirus HKU1</b>	<input type="checkbox"/> <b>Yes, positive</b>	<input type="checkbox"/> <b>Yes, negative</b>	<input type="checkbox"/> <b>Not tested/Unknown</b>	Date: ____/____/____
1k. <b>Coronavirus NL63</b>	<input type="checkbox"/> <b>Yes, positive</b>	<input type="checkbox"/> <b>Yes, negative</b>	<input type="checkbox"/> <b>Not tested/Unknown</b>	Date: ____/____/____
1l. <b>Coronavirus OC43</b>	<input type="checkbox"/> <b>Yes, positive</b>	<input type="checkbox"/> <b>Yes, negative</b>	<input type="checkbox"/> <b>Not tested/Unknown</b>	Date: ____/____/____
1m. Coronavirus SARS-CoV-2	<input type="checkbox"/> Yes, positive	<input type="checkbox"/> Yes, negative	<input type="checkbox"/> Not tested/Unknown	Date: ____/____/____
1n. <b>Coronavirus (not further specified)</b>	<input type="checkbox"/> <b>Yes, positive</b>	<input type="checkbox"/> <b>Yes, negative</b>	<input type="checkbox"/> <b>Not tested/Unknown</b>	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

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

2b. Start date: \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown

3. Vasopressor use?  Yes  No  Unknown  
 (Common vasopressors are Dobutamine, Dopamine, Epinephrine, Milrinone, Neosynephrine, Norepinephrine, Vasopressin)

4. Additional Treatment Comments:  
 \_\_\_\_\_

**L. Chest X-ray – Based on radiology report only**

1. Was a chest x-ray taken within 3 days after admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	2. Were any of these chest x-rays abnormal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	2a. Date of first abnormal chest x-ray: ____/____/____
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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"/> <b>Infiltrate (lung, interstitial, other)</b>	<input type="checkbox"/> Emphyema
<input type="checkbox"/> Air space density	<input type="checkbox"/> Consolidation	<input type="checkbox"/> Lobar infiltrate	<input type="checkbox"/> Other
<input type="checkbox"/> Air space opacity	<input type="checkbox"/> Cavitation	<input type="checkbox"/> Pleural Effusion	
<input type="checkbox"/> Bronchopneumonia/pneumonia	<input type="checkbox"/> ARDS (acute respiratory distress syndrome)		

**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 complication of sickle cell	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Disseminated intravascular coagulation (DIC)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
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
Atrial fibrillation (Afib) new-onset or paroxysmal/chronic	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Pulmonary embolism (PE)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Bacteremia	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Reye's Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Bronchiolitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Rhabdomyolysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Sepsis	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Cardiac arrest	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Chronic lung disease of prematurity/BPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Stroke (CVA)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Congestive heart failure exacerbation	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Supraventricular tachycardia (SVT)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
COPD exacerbation	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Toxic shock syndrome (TSS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Deep vein thrombosis (DVT)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Ventricular fibrillation (Vfib)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Diabetic ketoacidosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Ventricular tachycardia (V-tach)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown

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

ICD-10-CM codes available?  Yes  No

1. \_\_\_\_\_ 4. \_\_\_\_\_ 7. \_\_\_\_\_  
 2. \_\_\_\_\_ 5. \_\_\_\_\_ 8. \_\_\_\_\_  
 3. \_\_\_\_\_ 6. \_\_\_\_\_ 9. \_\_\_\_\_

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

1. Total # of pregnancies to date as of date of admission (Gravida, G): \_\_\_\_\_  Unknown  
 2. Total # of pregnancies to date 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. Pregnancy complications during current pregnancy? (Select all that apply):  
 None  Pre-eclampsia  Intrauterine growth restriction (IUGR)  
 Gestational diabetes  Pregnancy-induced hypertension (PIH)  Unknown

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

6a. If patient was pregnant on admission but no longer pregnant at discharge, indicate pregnancy outcome at discharge. (If multiple fetuses, indicate outcome at discharge for each fetus in the database separately.)

Healthy newborn } (if Healthy newborn, ill newborn or infant died, go to 6b.)  
 Ill newborn }  
 Infant died }  
 Miscarriage (intrauterine death at < 20 weeks GA)  
 Stillbirth (intrauterine death at ≥ 20 weeks GA)  
 Abortion  
 Unknown

6b. Pre-term live birth? (< 37 weeks GA)

Yes  Preterm delivery, gestational age in weeks: \_\_\_\_\_  
 No  
 Unknown

6c. If no longer pregnant, indicate date of delivery or end of pregnancy: \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown



**P. Influenza Vaccination History**

Specify vaccination status and date(s) by source:

1. Medical Chart:  Yes, full date known  No  Not Checked  
 Yes, specific date unknown  Unknown  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  No  Not Checked  
 Yes, specific date unknown  Unknown  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  No  Not Checked  
 Yes, specific date unknown  Unknown  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  Yes, full date known  No  Not Checked  
 Proxy  Yes, specific date unknown  Unknown  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**

Large empty text area for additional comments.