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

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:** _____

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:
☐ Surveillance Discharge Audit

2. State:

3. County:

4. Case Type:
☐ Pediatric
☐ Adult

5. Date of Birth:
____/____/_____

6. Age: _____
☐ Years
☐ Months (if < 1 yr)
☐ Days (if < 1 month)

7. Sex:
☐ Male
☐ Female

8. Race *(select all that apply):*
☐ White
☐ Black or African American
☐ Asian
☐ Native Hawaiian or other Pacific Islander
☐ American Indian or Alaska Native
☐ Multiracial, not otherwise specified
☐ Not specified

9. Ethnicity:
☐ Hispanic or Latino
☐ Non-Hispanic/Latino
☐ Not Specified

10. Was patient discharged from any hospital within 1 week prior to the current admission date?
☐ Yes ☐ No ☐ Unknown

11. Type of Insurance *(select all that apply):*
☐ Private
☐ Medicare
☐ Medicaid/state assistance program
☐ Military
☐ Indian Health Service
☐ Incarcerated
☐ Uninsured
☐ Unknown
☐ Other, specify: _____

12. Pregnant? (15-49 years of age only)**:**
☐ Yes ☐ No/Unknown
☐ Not applicable
(male/pregnant outside of applicable age range)

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
☐ Private residence with services
☐ Homeless/Shelter/Temporary housing
☐ Nursing home/Skilled nursing facility
☐ Substance abuse treatment center
☐ Hospitalized at birth
☐ Rehabilitation facility
☐ Corrections facility
☐ Hospice
☐ Assisted living/Residential care
☐ LTACH
☐ Group/Retirement home
☐ Psychiatric facility
☐ Other long term care facility
☐ Other, specify: _____
☐ Unknown

Case ID: _____

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) ☐ 2009 H1N1 ☐ H1, Unspecified ☐ H1, Seasonal ☐ H1 ☐ H3 ☐ Flu A, Unsubtypable ☐ Flu B (no lineage) ☐ Flu B, Victoria ☐ Flu B, Yamagata ☐ Flu A & B ☐ Flu A/B (not distinguished) ☐ Unknown Type ☐ Negative ☐ H3N2v ☐ Other, please specify: _____

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) ☐ 2009 H1N1 ☐ H1, Unspecified ☐ H1, Seasonal ☐ H1 ☐ H3 ☐ Flu A, Unsubtypable ☐ Flu B (no lineage) ☐ Flu B, Victoria ☐ Flu B, Yamagata ☐ Flu A & B ☐ Flu A/B (not distinguished) ☐ Unknown Type ☐ Negative ☐ H3N2v ☐ Other, please specify: _____

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) ☐ 2009 H1N1 ☐ H1, Unspecified ☐ H1, Seasonal ☐ H1 ☐ H3 ☐ Flu A, Unsubtypable ☐ Flu B (no lineage) ☐ Flu B, Victoria ☐ Flu B, Yamagata ☐ Flu A & B ☐ Flu A/B (not distinguished) ☐ Unknown Type ☐ Negative ☐ H3N2v ☐ Other, please specify: _____

3b. Specimen collection date: **3c. Specimen ID:** _____ **3d. Testing facility ID:** _____

E. Other Interventions and ICU

1. BiPAP or CPAP? ☐ Yes ☐ No ☐ Unknown

2. High flow nasal cannula (e.g., Vapotherm)? ☐ Yes ☐ No ☐ Unknown

3. Invasive mechanical ventilation? ☐ Yes ☐ No ☐ Unknown

4. ECMO? ☐ Yes ☐ No ☐ Unknown

5. 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)

6. Was the patient admitted to an intensive care unit (ICU)? ☐ Yes ☐ No ☐ Unknown

6a. Date of 1st ICU Admission: ____/____/_____ ☐ Unknown

6b. Date of 1st ICU Discharge: ____/____/_____ ☐ Unknown

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/Temporary housing
☐ Nursing home/Skilled nursing facility
☐ Substance abuse treatment center
☐ 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:

Case ID: _____

G. Admission and Patient History

1. Reason for admission:

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

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/tightness
☐ Conjunctivitis
☐ Diarrhea
☐ Dysgeusia/Decreased taste
☐ Fatigue
☐ Fever/chills
☐ Headache
☐ Muscle aches/myalgias
☐ Nausea/vomiting
☐ Rash
☐ Seizures

Respiratory symptoms

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

For cases < 12 years

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

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. Alcohol abuse:

☐ Current ☐ Former ☐ No/Unknown

9. Substance abuse:

☐ Current ☐ Former ☐ No/Unknown

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

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

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

Case ID: _____

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

Case ID: _____

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?

☐ Blood
☐ Bone/joint aspirate
☐ Bronchoalveolar lavage (BAL), bronchial aspirate/wash
☐ Cerebrospinal fluid (CSF)
☐ Endotracheal/tracheal aspirate
☐ Peritoneal or abdominal fluid/ascites
☐ Pleural fluid
☐ Sputum
☐ Wound - Group A Streptococcus (only)
☐ Other, specify: _____

1b. Date of specimen collection for culture	1c. Result of culture:	1d. If positive, what pathogen was identified?	1e. If Staphylococcus aureus, specify:
____/____/_____	☐ Positive ☐ Negative ☐ Unknown	☐ Bacteria, specify: ☐ Aspergillus (fungus) ☐ Mucormycosis (fungus)	☐ Methicillin resistant (MRSA) ☐ Methicillin sensitive (MSSA) ☐ Sensitivity unknown

Specimen 2

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

☐ Blood
☐ Bone/joint aspirate
☐ Bronchoalveolar lavage (BAL), bronchial aspirate/wash
☐ Cerebrospinal fluid (CSF)
☐ Endotracheal/tracheal aspirate
☐ Peritoneal or abdominal fluid/ascites
☐ Pleural fluid
☐ Sputum
☐ Wound - Group A Streptococcus (only)
☐ Other, specify: _____

2b. Date of specimen collection for culture	2c. Result of culture:	2d. If positive, what pathogen was identified?	2e. If Staphylococcus aureus, specify:
____/____/_____	☐ Positive ☐ Negative ☐ Unknown	☐ Bacteria, specify: ☐ Aspergillus (fungus) ☐ Mucormycosis (fungus)	☐ Methicillin resistant (MRSA) ☐ Methicillin sensitive (MSSA) ☐ Sensitivity unknown

Specimen 3

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

☐ Blood
☐ Bone/joint aspirate
☐ Bronchoalveolar lavage (BAL), bronchial aspirate/wash
☐ Cerebrospinal fluid (CSF)
☐ Endotracheal/tracheal aspirate
☐ Peritoneal or abdominal fluid/ascites
☐ Pleural fluid
☐ Sputum
☐ Wound - Group A Streptococcus (only)
☐ Other, specify: _____

3b. Date of specimen collection for culture	3c. Result of culture:	3d. If positive, what pathogen was identified?	3e. If Staphylococcus aureus, specify:
____/____/_____	☐ Positive ☐ Negative ☐ Unknown	☐ Bacteria, specify: ☐ Aspergillus (fungus) ☐ Mucormycosis (fungus)	☐ Methicillin resistant (MRSA) ☐ Methicillin sensitive (MSSA) ☐ Sensitivity unknown

Specimen 4

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

☐ Blood
☐ Bone/joint aspirate
☐ Bronchoalveolar lavage (BAL), bronchial aspirate/wash
☐ Cerebrospinal fluid (CSF)
☐ Endotracheal/tracheal aspirate
☐ Peritoneal or abdominal fluid/ascites
☐ Pleural fluid
☐ Sputum
☐ Wound - Group A Streptococcus (only)
☐ Other, specify: _____

4b. Date of specimen collection for culture	4c. Result of culture:	4d. If positive, what pathogen was identified?	4e. If Staphylococcus aureus, specify:
____/____/_____	☐ Positive ☐ Negative ☐ Unknown	☐ Bacteria, specify: ☐ Aspergillus (fungus) ☐ Mucormycosis (fungus)	☐ Methicillin resistant (MRSA) ☐ Methicillin sensitive (MSSA) ☐ Sensitivity unknown

Case ID: _____

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	☐ 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 229E	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____
1j. Coronavirus HKU1	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____
1k. Coronavirus NL63	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____
1l. Coronavirus OC43	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____
1m. Coronavirus SARS-CoV-2	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____
1n. Coronavirus (not further specified)	☐ 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

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? ☐ 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)
☐ Infiltrate (lung, interstitial, other)
☐ Lobar infiltrate
☐ Pleural Effusion
☐ Empyema
☐ Other

Case ID: _____

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	☐ Yes	☐ No/Unknown	Disseminated intravascular coagulation (DIC)	☐ Yes	☐ No/Unknown
Acute encephalopathy/encephalitis	☐ Yes	☐ No/Unknown	Guillain-Barre syndrome	☐ Yes	☐ No/Unknown
Acute liver failure	☐ Yes	☐ No/Unknown	Hemophagocytic syndrome	☐ Yes	☐ No/Unknown
Acute myocardial infarction	☐ Yes	☐ No/Unknown	Invasive pulmonary aspergillosis	☐ Yes	☐ No/Unknown
Acute myocarditis	☐ Yes	☐ No/Unknown	Kawasaki disease	☐ Yes	☐ No/Unknown
Acute renal failure/acute kidney injury	☐ Yes	☐ No/Unknown	Mucormycosis	☐ 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
Atrial fibrilation (Afib) new-onset or paroxysmal/chronic	☐ Yes	☐ No/Unknown	Pulmonary embolism (PE)	☐ Yes	☐ No/Unknow
Bacteremia	☐ Yes	☐ No/Unknown	Reye's Syndrome	☐ Yes	☐ No/Unknown
Bronchiolitis	☐ Yes	☐ No/Unknown	Rhabdomyolysis	☐ Yes	☐ No/Unknown
Bronchitis	☐ Yes	☐ No/Unknown	Sepsis	☐ Yes	☐ No/Unknown
Cardiac arrest	☐ Yes	☐ No/Unknown	Seizures	☐ Yes	☐ No/Unknown
Chronic lung disease of prematurity/BPD	☐ Yes	☐ No/Unknown	Stroke (CVA)	☐ Yes	☐ No/Unknown
Congestive heart failure exacerbation	☐ Yes	☐ No/Unknown	Supraventricular tachycardia (SVT)	☐ Yes	☐ No/Unknown
COPD exacerbation	☐ Yes	☐ No/Unknown	Toxic shock syndrome (TSS)	☐ Yes	☐ No/Unknown
Deep vein thrombosis (DVT)	☐ Yes	☐ No/Unknown	Ventricular fibrillation (Vfib)	☐ Yes	☐ No/Unknown
Diabetic ketoacidosis	☐ Yes	☐ No/Unknown	Ventricular tachycardia (V-tach)	☐ Yes	☐ 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) ☐ 3rd (28 0/7 to end)
☐ 2nd (14 0/7 to 27 6/7 weeks) ☐ 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. (If multiple fetuses, indicate outcome at discharge for each fetus in the database separately.)

☐ Healthy newborn
☐ Ill newborn
☐ Infant died
(if Healthy newborn, ill newborn or infant died, go to 6b.) →
☐ 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
☐ No
☐ Unknown
☐ Preterm delivery, gestational age in weeks: _____

5c. If no longer pregnant, indicate date of delivery or end of pregnancy: ____/____/_____ ☐ Unknown

Case ID: _____

P. Influenza 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