

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 and/or Ethnicity (select all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Middle Eastern or North African ☐ Multiracial, not otherwise specified ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Unknown	9. Was patient discharged from any hospital within 1 week prior to the current admission date? ☐ Yes ☐ No ☐ Unknown	10. Type of Insurance (select all that apply): ☐ Private ☐ Medicare ☐ Medicaid/state assistance program ☐ Military ☐ Indian Health Service ☐ Incarcerated ☐ Uninsured ☐ Unknown ☐ Other, specify: _____		11. Pregnant? (15-49 years of age only): ☐ Yes ☐ No/Unknown ☐ Not applicable (male/pregnant outside of applicable age range) 12. Hospital ID Where Patient Treated: _____ 12a. Admission Date: ____/____/____ 12b. Discharge Date: ____/____/____																		
13. Was patient transferred from another hospital? ☐ Yes ☐ No ☐ Unknown	13a. Transfer Hospital ID: _____		13b. Transfer Hospital Admission Date: ____/____/____ 13c. Transfer Date: ____/____/____																			
14. Where did the patient reside at the time of hospitalization? (Indicate TYPE of residence.) <table><tr><td>☐ Private residence</td><td>☐ Substance abuse treatment center</td><td>☐ Hospice</td><td>☐ Psychiatric/Behavioral Health Facility</td></tr><tr><td>☐ Private residence with services</td><td>☐ Hospitalized at birth</td><td>☐ Assisted living/Residential care</td><td>☐ Other long term care facility</td></tr><tr><td>☐ Homeless/Shelter/Temporary housing</td><td>☐ Rehabilitation facility</td><td>☐ LTACH</td><td>☐ Unknown</td></tr><tr><td>☐ Nursing home/Skilled nursing facility</td><td>☐ Corrections facility</td><td>☐ Group/Retirement home</td><td>☐ Other, specify: _____</td></tr></table>							☐ Private residence	☐ Substance abuse treatment center	☐ Hospice	☐ Psychiatric/Behavioral Health Facility	☐ Private residence with services	☐ Hospitalized at birth	☐ Assisted living/Residential care	☐ Other long term care facility	☐ Homeless/Shelter/Temporary housing	☐ Rehabilitation facility	☐ LTACH	☐ Unknown	☐ Nursing home/Skilled nursing facility	☐ Corrections facility	☐ Group/Retirement home	☐ Other, specify: _____
☐ Private residence	☐ Substance abuse treatment center	☐ Hospice	☐ Psychiatric/Behavioral Health Facility																			
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☐ Homeless/Shelter/Temporary housing	☐ Rehabilitation facility	☐ LTACH	☐ Unknown																			
☐ Nursing home/Skilled nursing facility	☐ Corrections facility	☐ Group/Retirement home	☐ Other, specify: _____																			
14a. If resident of a facility indicate NAME of facility: _____																						

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)

1. Test 1: ☐ Rapid Antigen ☐ Viral Culture ☐ Method Unknown
☐ Standard/Rapid Molecular Assay ☐ Fluorescent Antibody

1a. Result: ☐ Flu A (no subtype) ☐ H1, Seasonal ☐ Flu A, Unsubtypable ☐ Flu B, Yamagata ☐ Unknown Type ☐ Other, please specify:
☐ 2009 H1N1 ☐ H1 ☐ Flu B (no lineage) ☐ Flu A & B ☐ Negative
☐ H1, Unspecified ☐ H3 ☐ Flu B, Victoria ☐ Flu A/B (not distinguished) ☐ H3N2v

1b. Specimen collection date: ____/____/____ **1c. Specimen ID:** ____ **1d. Testing facility ID:** ____

2. Test 2: ☐ Rapid Antigen ☐ Viral Culture ☐ Method Unknown
☐ Standard/Rapid Molecular Assay ☐ Fluorescent Antibody

2a. Result: ☐ Flu A (no subtype) ☐ H1, Seasonal ☐ Flu A, Unsubtypable ☐ Flu B, Yamagata ☐ Unknown Type ☐ Other, please specify:
☐ 2009 H1N1 ☐ H1 ☐ Flu B (no lineage) ☐ Flu A & B ☐ Negative
☐ H1, Unspecified ☐ H3 ☐ Flu B, Victoria ☐ Flu A/B (not distinguished) ☐ H3N2v

2b. Specimen collection date: ____/____/____ **2c. Specimen ID:** _____ **2d. Testing facility ID:** _____

3. Test 3: ☐ Rapid Antigen ☐ Viral Culture ☐ Method Unknown
☐ Standard/Rapid Molecular Assay ☐ Fluorescent Antibody

3a. Result: ☐ Flu A (no subtype) ☐ H1, Seasonal ☐ Flu A, Unsubtypable ☐ Flu B, Yamagata ☐ Unknown Type ☐ Other, please specify:
☐ 2009 H1N1 ☐ H1 ☐ Flu B (no lineage) ☐ Flu A & B ☐ Negative
☐ H1, Unspecified ☐ H3 ☐ Flu B, Victoria ☐ Flu A/B (not distinguished) ☐ H3N2v

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

E. Other Interventions and ICU (For Questions 1-5, select the highest level of oxygen support received)

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. Supplemental Oxygen? ☐ Yes ☐ No ☐ Unknown		6. 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)			

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

7a. Date of 1st ICU Admission: ____/____/____ ☐ Unknown

7b. 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	☐ Corrections facility	☐ Other long term care facility
☐ Private residence with services	☐ Hospice	☐ Against medical advice (AMA)
☐ Homeless/Shelter/Temporary housing	☐ Assisted living/Residential care	☐ Discharged to another hospital
☐ Nursing home/Skilled nursing facility	☐ LTACH	☐ Other, specify: _____
☐ Substance abuse treatment center	☐ Group/Retirement home	☐ Unknown
☐ Rehabilitation facility	☐ Psychiatric/Behavioral Health Facility	

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/hypoxia | ☐ 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 applicable4. Height: _____ ☐ Inch ☐ Cm
☐ Unknown5. Weight: _____ ☐ Lbs ☐ Kg
☐ Unknown6. BMI: (non-pregnant cases and cases ≥ 2 years only) _____ ☐ Unknown

7. Smoker (tobacco) (for patients > 12 years):

- ☐
- Current
- ☐
- Former
- ☐
- No/Unknown

8. Environmental tobacco smoke exposure (for pediatric patients ≤ 12 years):

- ☐
- Yes
- ☐
- No
- ☐
- Unknown

9. Alcohol misuse (for patients > 12 years):

- ☐
- Current
- ☐
- Former
- ☐
- No/Unknown

10. Substance misuse (for patients > 12 years):

- ☐
- Current
- ☐
- Former
- ☐
- No/Unknown

11. Substance Misuse Type or Route (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. Diabetes Mellitus (DM): ☐ Yes ☐ No/Unknown

1d. Chronic Metabolic Disease: ☐ Yes ☐ No/Unknown

- ☐ Adrenal Disorders (*Addison's disease, adrenal insufficiency, Cushing syndrome, congenital adrenal hyperplasia*)
- ☐ 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*)

1e. 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

1f. Hypertension (HTN): ☐ Yes ☐ No/Unknown

1g. 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
 - ☐ Patent Ductus Arteriosus (PDA)
 - ☐ 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)

1h. 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

1i. History of Guillain-Barre Syndrome:

☐ Yes ☐ No/Unknown

1j. 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

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 Any Obesity:

☐ Yes ☐ No/Unknown

- ☐ Obese
- ☐ Severely/morbidly obese (ADULTS ONLY)

1m. Post-partum (two weeks or less):

☐ Yes ☐ No/Unknown

1n. 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)

1o. 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)

1p. Mental Health Conditions:

☐ Yes ☐ No/Unknown

- ☐ Bipolar disorder
- ☐ Depression
- ☐ Schizophrenia spectrum disorder

1q. Other:

☐ Yes ☐ No/Unknown

- ☐ Bedbound
- ☐ Feeding tube dependent (PEG, see list)
- ☐ Trach dependent/Vent dependent
- ☐ Wheelchair dependent
- ☐ Other, specify: _____

1r. 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. 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. Coronavirus SARS-CoV-2	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	Date: ____/____/____		
1c. Adenovirus	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	Date: ____/____/____		
1d. Parainfluenza 1	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	Date: ____/____/____		
1e. Parainfluenza 2	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	Date: ____/____/____		
1f. Parainfluenza 3	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	Date: ____/____/____		
1g. Parainfluenza 4	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	Date: ____/____/____		
1h. Human metapneumovirus	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	Date: ____/____/____		
1i. Rhinovirus/Enterovirus	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	Date: ____/____/____		
1j. Coronavirus 229E	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	Date: ____/____/____		
1k. Coronavirus HKU1	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	Date: ____/____/____		
1l. Coronavirus NL63	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	Date: ____/____/____		
1m. Coronavirus OC43	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	Date: ____/____/____		
1n. Coronavirus (not further specified)	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	Date: ____/____/____		

J. 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:

K. Chest X-ray – Based on radiology report only

1. Was a chest x-ray taken during the first 3 days of admission (for patients ≤17 years)?	☐ Yes	☐ No	☐ Unknown
---	------------------------------	-----------------------------	----------------------------------

L. 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 fibrillation (Afib) new-onset or paroxysmal/chronic	☐ Yes	☐ No/Unknown	Pulmonary embolism (PE)	☐ Yes	☐ No/Unknown
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

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

ICD-10-CM codes available? ☐ Yes ☐ No

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

N. 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
☐ 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

O. 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
- ☐ Proxy

- ☐ Yes, full date known
- ☐ No
- ☐ Not Checked
- ☐ 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

P. Additional Comments

Case ID: _____

R. COVID-19 Vaccine History (Additional products will be listed in the database as FDA authorization/emergency use authorization received)

1. Vaccine registry:

- ☐ Registry reviewed
- ☐ Registry available but not reviewed (specify): _____
- ☐ Registry not available for review

2. COVID-19 vaccine doses received (For cases ≥ 6 years old, record all doses of COVID-19 vaccine received on/after August 31, 2022. For cases < 6 years old, record all available doses of COVID-19 vaccine)

FOR COVID-NET CASE PATIENTS ≥ 6 YEARS OLD:

Dose Date	Dose Product	Dose Source
____/____/____ Month Day Year ☐ Unk. ☐ Unk. ☐ Unk.	Vaccines available as of Fall 2023 ☐ 2023 Pfizer-BioNTech COVID-19 Vaccine, Monovalent (XBB.1.5) ☐ 2023 Moderna COVID-19 Vaccine, Monovalent (XBB.1.5) Vaccines available prior to Fall 2023 ☐ Pfizer-BioNTech COVID-19 Vaccine, Bivalent (COMIRNATY/ bivalent BNT162b2 -or- Original and Omicron BA.4/BA.6) ☐ Moderna COVID-19 Vaccine, Bivalent (mRNA-1273.214) ☐ Janssen Pharmaceuticals (JNJ-78436735) ☐ Novavax COVID-19 Vaccine, Adjuvanted (NVX-CoV2373, Covovax) ☐ AstraZeneca (AZD1222) ☐ Unknown ☐ Other, specify: _____	☐ Registry

FOR COVID-NET CASE-PATIENTS ≥ 6 MONTHS- < 6 YEARS OLD:

Dose Date	Dose Product	Dose Source
____/____/____ Month Day Year ☐ Unk. ☐ Unk. ☐ Unk.	Vaccines available as of Fall 2023 ☐ 2023 Pfizer-BioNTech COVID-19 Vaccine, Monovalent (XBB.1.5) ☐ 2023 Moderna COVID-19 Vaccine, Monovalent (XBB.1.5) Vaccines available prior to Fall 2023 ☐ Pfizer-BioNTech COVID-19 Vaccine, Bivalent (COMIRNATY) ☐ Moderna COVID-19 Vaccine, Bivalent (Spikevax) ☐ Pfizer-BioNTech COVID-19 Vaccine, Monovalent or (COMIRNATY/ Monovalent BNT162b2) ☐ Moderna COVID-19 Vaccine, Monovalent (Spikevax, mRNA-1273) ☐ Unknown ☐ Other, specify: _____	☐ Registry