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

# 2024-25 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.)**
☐ 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/Behavioral Health Facility
☐ Other long term care facility
☐ Unknown
☐ Other, specify: _____

**14a.** If resident of a facility indicate NAME of facility: _____

**Case ID:** _____

## D. Influenza Testing Results *(can add up to 4 test results in database)*

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

**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 ☐ Standard/Rapid Molecular Assay ☐ Viral Culture ☐ Fluorescent Antibody ☐ Method Unknown/Provider note only

**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 ☐ Standard/Rapid Molecular Assay ☐ Viral Culture ☐ Fluorescent Antibody ☐ Method Unknown/Provider note only

**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 *(For Questions 2-5, select the highest level of respiratory support received)*

**1. ECMO?** ☐ Yes ☐ No ☐ Unknown

**2. Invasive mechanical ventilation?** ☐ Yes ☐ No ☐ Unknown

**3. BiPAP or CPAP?** ☐ Yes ☐ No ☐ Unknown

**4. High flow nasal cannula (e.g., Vapotherm)?** ☐ 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
☐ 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/Behavioral Health 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 (*Select all that apply):***

- ☐ 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/hypoxia
- ☐ 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) (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
- ☐ IVDU
- ☐ Opioids
- ☐ Polysubstance abuse - not otherwise specified
- ☐ Methamphetamines
- ☐ Marijuana
- ☐ Other, specify: _____
- ☐ Unknown

**12. 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. 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

**Case ID:** _____

## 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 strictures
- ☐ Esophageal varices
- ☐ 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

**Case ID:** _____

## 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 during the course of illness?** ☐ 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

**Case ID:** _____

## 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 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 |

## M. 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. _____

## 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 reached viable gestational age 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. 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
*(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

**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

**Case ID:** _____

## O. 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

## P. Additional Comments