

2026-27 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:		
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

1. Case Classification: <input type="checkbox"/> Surveillance Discharge Audit <input type="checkbox"/> Observation Only	2. State: _____	3. County: _____	4. Case Type: <input type="checkbox"/> Pediatric <input type="checkbox"/> Adult	5. Date of Birth: ____/____/____	6. Age: <input type="checkbox"/> Years <input type="checkbox"/> Months (if < 1 yr) <input type="checkbox"/> Days (if < 1 month)	7. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
8. Race and/or Ethnicity (select all that apply): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Multiracial, not otherwise specified <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown		9. Was patient discharged from any hospital within 1 week prior to the current admission date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		10. Type of Insurance (select all that apply): <input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid/state assistance program <input type="checkbox"/> Military <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Incarcerated <input type="checkbox"/> Uninsured <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____		11. Pregnant? (15-49 years of age only): <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	
13. Was patient transferred from another hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			13a. Transfer Hospital ID: _____		13b. Transfer Hospital Admission Date: ____/____/____		
14. Where did the patient reside at the time of hospitalization? (Indicate TYPE of residence.) <input type="checkbox"/> Private residence <input type="checkbox"/> Private residence with services <input type="checkbox"/> Homeless/Shelter/Temporary housing <input type="checkbox"/> Nursing home/Skilled nursing facility			<input type="checkbox"/> Substance abuse treatment center <input type="checkbox"/> Hospitalized at birth <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Corrections facility		<input type="checkbox"/> Hospice <input type="checkbox"/> Assisted living/Residential care <input type="checkbox"/> LTACH <input type="checkbox"/> Group/Retirement home		
14a. If resident of a facility indicate NAME of facility: _____			<input type="checkbox"/> Psychiatric/Behavioral Health Facility <input type="checkbox"/> Other long term care facility <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____				

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/Provider note only
 Standard/Rapid Molecular Assay Fluorescent Antibody

1a. Result: Flu A (no subtype) H3 Flu B (no lineage) Flu A & B Negative
 2009 H1N1 H5 Flu B, Victoria Flu A/B (not distinguished) H3N2v
 H1 Flu A, Unsubtypable Flu B, Yamagata Unknown Type Other, please specify: _____

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

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

2a. Result: Flu A (no subtype) H3 Flu B (no lineage) Flu A & B Negative
 2009 H1N1 H5 Flu B, Victoria Flu A/B (not distinguished) H3N2v
 H1 Flu A, Unsubtypable Flu B, Yamagata Unknown Type Other, please specify: _____

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

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

3a. Result: Flu A (no subtype) H3 Flu B (no lineage) Flu A & B Negative
 2009 H1N1 H5 Flu B, Victoria Flu A/B (not distinguished) H3N2v
 H1 Flu A, Unsubtypable Flu B, Yamagata Unknown Type Other, please specify: _____

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

E. Other Interventions and ICU

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 (CVWH), 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:

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

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 fever or acute respiratory symptoms

(within 2 weeks before a positive test), whichever is earlier: ____/____/____ Approximate date entered 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

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 strictures
- Esophageal varices
- Hepatitis B, chronic (HBV)
- Hepatitis C, chronic (HCV)
- Non-alcoholic fatty liver disease (NAFLD)/NASH/Metabolic dysfunction-associated steatotic liver disease (MASLD)
- 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

For pediatric patients <2 years old: Premature? (gestational age < 37 weeks at birth)

- Yes
If yes, specify gestational age at birth in weeks: _____
 Unknown gestational age at birth
- No
- Unknown

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

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Diabetic ketoacidosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Acute encephalopathy/encephalitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Disseminated intravascular coagulation (DIC)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Acute necrotizing encephalopathy/encephalitis (ANE)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Guillain-Barre syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Influenza-associated encephalopathy/encephalitis (IAE)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Hemophagocytic syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Acute liver failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Invasive pulmonary aspergillosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Acute myocardial infarction	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Kawasaki disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Acute myocarditis	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Mucormycosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Acute renal failure/acute kidney injury	<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 distress syndrome (ARDS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Other thrombosis/embolism/coagulopathy	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Acute respiratory failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Asthma exacerbation	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Pulmonary embolism (PE)	<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	Reye's Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Bacteremia	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Rhabdomyolysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Bronchiolitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Sepsis	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Cardiac arrest	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Stroke (CVA)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Chronic lung disease of prematurity/BPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Supraventricular tachycardia (SVT)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Congestive heart failure exacerbation	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Toxic shock syndrome (TSS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
COPD exacerbation	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Ventricular fibrillation (Vfib)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown
Deep vein thrombosis (DVT)	<input type="checkbox"/> Yes	<input type="checkbox"/> No/Unknown	Ventricular tachycardia (V-tach)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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): _____ <input type="checkbox"/> Unknown	2. Total # of pregnancies to date that reached viable gestational age as of date of admission (Parity, P): _____ <input type="checkbox"/> Unknown	3. Specify total # of fetuses for current pregnancy as of date of admission <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> > 3 <input type="checkbox"/> Unknown
4. Specify gestational age in weeks as of date of admission: _____ <input type="checkbox"/> Unknown If gestational age in weeks unknown, specify trimester of pregnancy: <input type="checkbox"/> 1st (0 to 13 6/7 weeks) <input type="checkbox"/> 2nd (14 0/7 to 27 6/7 weeks) <input type="checkbox"/> 3rd (28 0/7 to end) <input type="checkbox"/> Unknown		
5. Pregnancy complications during current pregnancy? (Select all that apply): <input type="checkbox"/> None <input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Intrauterine growth restriction (IUGR) <input type="checkbox"/> Gestational diabetes <input type="checkbox"/> Pregnancy-induced hypertension (PIH) <input type="checkbox"/> Unknown		
6. Indicate pregnancy status at discharge or death: <input type="checkbox"/> Still pregnant <input type="checkbox"/> No longer pregnant <input type="checkbox"/> 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.) <input type="checkbox"/> Healthy newborn } (if Healthy newborn, ill newborn or infant died, go to 6b.) <input type="checkbox"/> Ill newborn } <input type="checkbox"/> Infant died } <input type="checkbox"/> Miscarriage (intrauterine death at < 20 weeks GA) <input type="checkbox"/> Stillbirth (intrauterine death at ≥ 20 weeks GA) <input type="checkbox"/> Abortion <input type="checkbox"/> Unknown		6b. Pre-term live birth? (< 37 weeks GA) <input type="checkbox"/> Yes <input type="checkbox"/> Preterm delivery, gestational age in weeks: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
6c. If no longer pregnant, indicate date of delivery or end of pregnancy: ____/____/____ <input type="checkbox"/> 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 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

P. Additional Comments (For Site Use Only)

Blank area for additional comments.