Influenza-Associated Pediatric Deaths Case Report Form

Form approved
OMB No. 0920-0007

STATE USE ONLY – DO NOT SEND INFORMATION *IN THIS SECTION* TO CDC

Last Name: ______________________ First Name: ______________ County: ______________

Address: City: State, Zip:

Patient Demographics

1. State:	2. County:	3. State ID:	4. CDC ID:
5. Age: _____ ☐ Days ☐ Months ☐ Years	6. Date of birth: ____/____/____ MM DD YYYY	7.Sex: ☐ Male ☐ Female	8. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

9. Race: ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Unknown

Death Information

10. Date of illness onset: ____/____/____ MM DD YYYY	11. Date of death: ____/____/____ MM DD YYYY	12. Was an autopsy performed? ☐ Yes ☐ No

13. Location of death: ☐ Home ☐ Emergency Dept (ER) ☐ Inpatient ward ☐ ICU ☐ Other (specify): ______________

Influenza Testing (check all that were used)

Test Type	Result	Specimen Collection Date
☐ Commercial rapid diagnostic test	☐ Influenza A ☐ Influenza B ☐ Negative ☐ Influenza A/B (Not Distinguished)	____/____/____
☐ Viral culture	☐ Influenza A (Subtyping Not Done) ☐ Influenza B ☐ Negative ☐ Influenza A (Unable To Subtype) ☐ Influenza A (H1) ☐ Influenza A (H3)	____/____/____
☐ Direct fluorescent antibody (DFA)	☐ Influenza A ☐ Influenza B ☐ Negative ☐ Influenza A/B	____/____/____
☐ Indirect fluorescent antibody (IFA)	☐ Influenza A ☐ Influenza B ☐ Negative ☐ Influenza A/B	____/____/____
☐ Enzyme immunoassay (EIA)	☐ Influenza A (Subtyping Not Done) ☐ Influenza B ☐ Negative ☐ Influenza A (Unable To Subtype) ☐ Influenza A (H1) ☐ Influenza A (H3)	____/____/____
☐ RT-PCR	☐ Influenza A (Subtyping Not Done) ☐ Influenza B ☐ Negative ☐ Influenza A (Unable To Subtype) ☐ Influenza A (H1) ☐ Influenza A (H3)	____/____/____
☐ Immunohistochemistry (IHC)	☐ Influenza A ☐ Influenza B ☐ Negative	____/____/____

Culture confirmation of INVASIVE bacterial pathogens

14. Was an INVASIVE bacterial infection confirmed by culturing an organism from a specimen collected from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid)? ☐ Yes ☐ No

☐ *Streptococcus pneumoniae*	☐ *Staphylococcus aureus,* methicillin **sensitive**	☐ *Neisseria meningitidis (serogroup, if known):*_______
☐ *Haemophilus influenzae* type b	☐ *Staphylococcus aureus,* methicillin **resistant (MRSA)**	☐ Group A streptococcus
☐ *Haemophilus influenzae* not-type b	☐ *Staphylococcus aureus,* **sensitivity not done**	☐ Other invasive bacteria: ______________

Public reporting burden of this collection of information is estimated to average 20 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 Reports Clearance Officer; 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-0007).

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Medical Care

15. Did the patient receive medical care for this illness? ☐ Yes* ☐ No

16. **If YES*,** indicate level(s) of care received (check all that apply): ☐ Outpatient clinic ☐ ER ☐ Inpatient ward ☐ ICU

17. Did the patient require mechanical ventilation? ☐ Yes ☐ No

Clinical Diagnoses and Complications

18. **Check all complications that occurred during the acute illness:** ☐ **NONE**

☐ Pneumonia (Chest X-Ray confirmed) ☐ Acute Respiratory Disease Syndrome (ARDS) ☐ Croup ☐ Seizures

☐ Bronchiolitis ☐ Encephalopathy/encephalitis ☐ Reye syndrome ☐ Shock

☐ Another viral co-infection: ______________ ☐ Other: ______________

19. **Check all medical conditions that existed before the start of the acute illness:** ☐ **NONE**

☐ Moderate to severe developmental delay ☐ Hemaglobinopathy (e.g. sickle cell disease) ☐ Asthma/ reactive airway disease

☐ Diabetes mellitus ☐ History of febrile seizures ☐ Seizure disorder ☐ Cystic fibrosis

☐ Cardiac disease (specify) ______________ ☐ Renal disease (specify) ______________

☐ Chronic pulmonary disease (specify) ______________ ☐ Immunosuppressive condition (specify) ______________

☐ Metabolic disorder (specify) ______________ ☐ Neuromuscular disorder (including cerebral palsy) (specify) ______________

☐ Pregnant (specify gestational age) _______ weeks ☐ Other (specify) ______________

Medication and Therapy History

20. Was the patient receiving any of the following therapies prior to illness onset? **(check all that apply)**

☐ Aspirin or aspirin-containing products ☐ Steroids taken by mouth or injection ☐ Chemotherapy treatment for cancer ☐ Radiation therapy ☐ Any other immunosuppressive therapy: ______________

Influenza vaccine history

21. Did the patient receive any influenza vaccine during the current season (before illness) ☐ Yes* ☐ No

22. **If YES*,** please specify influenza vaccine received before illness onset: ☐ Trivalent inactivated influenza vaccine (TIV) *[injected]* ☐ Live-attenuated influenza vaccine (LAIV) *[nasal spray]*

23. **If YES*,** how many doses did the patient receive and what was the timing of each dose? (Enter vaccination dates if available)

☐ 1 dose **ONLY**	☐ <14 days prior to illness onset ☐ ≥14 days prior to illness onset	Date dose given: ______/______/______ MM DD YYYY	
☐ 2 doses	☐ 2nd dose given <14 days prior to onset ☐ 2nd dose given ≥14 days prior to onset	Date of 1st dose: ______/______/______ MM DD YYYY	Date of 2nd dose: ______/______/______ MM DD YYYY

24. Did the patient receive any influenza vaccine in previous seasons? ☐ Yes ☐ No ☐ Unknown

Submitted By: ______________

Phone No.: (_____) ______________ Date: ______/______/______ MM DD YYYY

Email address: ______________