Severe Influenza Case History Form (ICU and Fatal Cases Age 0-64 Years)

Case definition: 1) lab-confirmed flu of any type; and 2) hospitalized in an ICU OR expired at any location (e.g. hospital, ER, home)

REQUIRED INFORMATION (if only the boxed area is completed, please attach relevant medical records if available (H&P, micro results, discharge sum, etc))

☐**ICU case** ☐**Fatal case** Date of death: _____/_____/____

Last name ________________________ **First name**___________________ **DOB** _____/_____/_____

Street Address: ______________________________ **City** ___________________ **Zip Code** _________

Race: ☐ White ☐Black ☐Native American ☐ Asian/PI ☐ Other ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Sex:** ☐Female ☐Male **HCW**: ☐Yes ☐No ☐Unk

Influenza Lab Confirmation: ☐A -rapid test, culture or DFA positive only ☐A (H3) ☐Seasonal A H1N1 ☐A -2009 H1N1 ☐A -PCR positive, untypeable ☐A -PCR positive, subtyping not done ☐B

Hospital Name _______________________ **City** ______________ **Date of admission:** ____/____/___

LHD ___________________________ **LHD contact info:** ______________________________________

Date of onset of symptom(s) _____/_____/_____

Admit diagnosis ____________________________

Symptoms that occurred prior to admission

☐ Fever≥37.8 ☐Cough ☐Sore throat
☐Nausea/vomiting ☐ Myalgia ☐Diarrhea
☐Shortness of breath ☐ Altered mental status
☐Seizures ☐O_2 sat __% on RA
☐Other: ____________________________________
____

Significant past medical history

Cardiac disease	☐ Yes	☐ No	☐ Unk
Chronic pulmonary disorder	☐ Yes	☐ No	☐ Unk
Immunosuppression (e.g., cancer)	☐Yes	☐ No	☐ Unk
Metabolic disorder (e.g. DM, renal)	☐ Yes	☐ No	☐ Unk
Neuromuscular disorder (e.g. CP)	☐ Yes	☐ No	☐ Unk
Hemoglobinopathy (e.g. SCD)	☐ Yes	☐ No	☐ Unk
Genetic disorder (e.g. Downs)	☐ Yes	☐ No	☐ Unk
Immunosuppressive meds (e.g, steroids)	☐ Yes	☐No	☐ Unk
Gastrointestinal disease (e.g, GE reflux)	☐ Yes	☐No	☐ Unk

Prematurity ☐ Yes ☐ No ☐ Unk *If yes, #weeks gestation:_____*
Pregnant ☐ Yes ☐ No ☐Unk *If yes, EDC : ___/___/___*
Postpartum ☐ Yes ☐ No ☐*Unk If yes, delivery : ___/___/___*
Weight: ______ ☐kg ☐ lbs Height: ________ BMI: ____

Other conditions (e.g., hypertension)	☐ Yes	☐ No	☐ Unk

If YES for <u>any</u> of the above, please specify: ________
____

Vaccination Status

Vaccinated for flu >14 days prior? ☐Yes ☐No ☐Unk

If yes, number of doses: ☐One ☐Two

If yes, type of vaccine: ☐ Inactivated ☐ FluMist

Diagnostic/Laboratory Studies

Chest X-ray ☐Pos ☐Neg ☐Not done

Findings: ____________________________________
____

Other abnormal results (LP, MRI/CT, LFTs, etc.)
____
____

Method of influenza diagnosis

☐Rapid test ☐IFA/DFA ☐PCR ☐Culture
☐Other ______________________________________

2° bacterial infection: ☐Yes ☐No ☐Unk

If yes, ☐ community-acquired ☐ hospital-acquired

Specify pathogen:______________________________

Specimen source: ______________________________

Date collected: _____/______/_____

Other micro results: ____________________________
____

Clinical course

Antiviral treatment: ☐ Yes ☐No ☐Unk

Type: ______________________Dose: _____________

Dates of treatment: ____/____/____ to ____/_____/_____

Intubated ☐ Yes ☐No ☐Unk

Date of discharge: ____/____/____

Discharged to: ☐ Home ☐Rehab

Complications

☐ Pneumonia ☐ARDS ☐ Sepsis ☐ Renal failure
☐Enceph-alitis/alopathy ☐ Pulmonary embolus
☐ Other, specify: ______________________________
____

LHJs should fax this case report form to: **916-440-5984**

TO REPORT A CASE, PLEASE CONTACT INSERT LOCAL COUNTY INFORMATION HERE (Name & Tel #) AND FAX THIS FORM TO:
( )____________________. Please forward any available medical records (e.g. H&P, micro reports, discharge summary, autopsy report). Please contact your local health department or CDPH to report these cases ASAP so that we can assist with collection and shipment of specimens for further characterization.

The information requested on this form is required by the California Department of Public for purposes of identification and public health investigation.