

This form should be faxed to: (951) 358-5102

## SEVERE INFLUENZA CASE HISTORY FORM (ICU AND FATAL CASES AGE 0-64 YEARS)

CASE STATUS (check all that apply)			
<input type="checkbox"/> ICU    A case with laboratory-confirmed influenza requiring admission to an intensive care unit (ICU)			
<input type="checkbox"/> Fatal    A case with laboratory-confirmed influenza that has died at any location (e.g. hospital, emergency, home)			
PATIENT INFORMATION			
Last name	First name	Date of birth	
Street address	City	Zip code	Local health jurisdiction of residence
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
ONSET, VACCINATION HISTORY, HOSPITALIZATION AND DEATH INFORMATION			
Date of onset of symptoms	Received this season's influenza vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date received: Dose 1	Dose 2
If hospitalized, hospital name and location		Date of hospital admission	Date of hospital discharge
If died, date of death	If died, location of death (i.e. home, ED-name of hospital ED, etc.)		If died, autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
INFLUENZA LABORATORY TESTING INFORMATION (Please attach a copy of the test result, if available)			
Date of specimen collection	Specimen type (e.g. nasopharyngeal swabs, endotracheal aspirate, bronchoalveolar lavage)		
Influenza type and/or subtype Influenza A: <input type="checkbox"/> (H3) <input type="checkbox"/> (2009H1N1) <input type="checkbox"/> (A Unknown – PCR) <input type="checkbox"/> (A Unknown – rapid test, culture or DFA) <input type="checkbox"/> (A – PCR unsubtypeable (i.e. novel)) Influenza B: <input type="checkbox"/> (Yamagata) <input type="checkbox"/> (Victoria) <input type="checkbox"/> (B Unknown)			Where was testing performed?
REPORTING AGENCY INFORMATION			
Reporting local health jurisdiction	Name of reporter	Telephone number of reporter	
CLINICAL COURSE			
Received antiviral treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Type of antiviral <input type="checkbox"/> Oseltamivir <input type="checkbox"/> Zanamivir <input type="checkbox"/> Other   Specify other: _____		
Date antiviral treatment started	Date antiviral treatment ended	Intubated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Complications <input type="checkbox"/> Pneumonia <input type="checkbox"/> ARDS <input type="checkbox"/> Sepsis <input type="checkbox"/> Acute renal failure <input type="checkbox"/> Encephalitis/encephalopathy <input type="checkbox"/> Required vasopressor <input type="checkbox"/> Required hemodialysis <input type="checkbox"/> Pulmonary embolus <input type="checkbox"/> Secondary bacterial infection   If yes, specify organism: _____ <input type="checkbox"/> Other   Specify other: _____			
SIGNIFICANT PAST MEDICAL HISTORY			
Did the patient have underlying medical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<input type="checkbox"/> Cardiac disease <input type="checkbox"/> Chronic pulmonary disorder <input type="checkbox"/> Immunosuppression (e.g. cancer) <input type="checkbox"/> Immunosuppressive medications (e.g. chemotherapy, steroids)			
<input type="checkbox"/> Metabolic disorder (e.g. diabetes mellitus, renal) <input type="checkbox"/> Neurological disorder (e.g. cerebral palsy) <input type="checkbox"/> Hemoglobinopathy (e.g. sickle cell disease)			
<input type="checkbox"/> Genetic disorder (e.g. Downs) <input type="checkbox"/> Obesity   If obese, BMI (if known): ____ Height: ____ Weight: ____			
<input type="checkbox"/> Pregnant   If pregnant, estimated delivery date: _____			
<input type="checkbox"/> Postpartum   If postpartum, delivery date: _____ <input type="checkbox"/> Other conditions (e.g. hypertension, hyperlipidemia)			
If yes for any of the above, please specify: _____			
NOTES SECTION (Please attach relevant medical records if available)			

**TO REPORT A CASE, PLEASE CONTACT COUNTY OF RIVERSIDE DISEASE CONTROL AT (951) 358-5107 AND  
FAX THIS FORM TO: (951) 358-5102.**

**Please forward any available medical records (e.g. H&P, mirco reports, discharge summary, autopsy report) to Disease Control ASAP.**