

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

REQUIRED INFORMATION			
<b>CASE STATUS (check all that apply)</b>			
<input type="checkbox"/> ICU A case with laboratory-confirmed influenza hospitalized $\geq 24$ hours and 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)			
<b>PATIENT INFORMATION</b>			
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
<b>ONSET, HOSPITALIZATION AND DEATH INFORMATION</b>			
Date of onset of symptoms / /	Hospitalized $\geq 24$ hours? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	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
<b>INFLUENZA LABORATORY TESTING INFORMATION (Please attach a copy of the test result, if available)</b>			
Date of specimen collection / /	Specimen type (e.g. nasopharyngeal swabs, endotracheal aspirate, bronchoalveolar lavage)		
Influenza type and/or subtype <input type="checkbox"/> B <input type="checkbox"/> A – rapid test, culture or DFA positive only <input type="checkbox"/> A – PCR positive, subtyping not done <input type="checkbox"/> A (H3) <input type="checkbox"/> A (2009 H1N1) <input type="checkbox"/> A – PCR positive, unsubtypeable (i.e. novel)			Where was testing performed?
<b>REPORTING AGENCY INFORMATION</b>			
Reporting local health jurisdiction		Name of reporter	Telephone number of reporter
<b>OPTIONAL INFORMATION (Completion of this section is optional. If available, this information helps CDPH greatly in assessing new risk groups and revision of antiviral and vaccine guidances. Please attach relevant medical records if available.)</b>			
<b>CLINICAL COURSE</b>			
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: _____			
<b>SIGNIFICANT PAST MEDICAL HISTORY</b>			
<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: _____			
<b>NOTES SECTION</b>			

**TO REPORT A CASE, PLEASE CONTACT RIVERSIDE COUNTY DISEASE CONTROL AT (951) 358-5107 AND FAX THIS FORM TO:  
(951) 358-5102. Please forward any available medical records (e.g. H&P, micro reports, discharge summary, autopsy report) to Disease Control ASAP  
for review of cases.**