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 (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 Laboratory Confirmation: ☐ A - rapid test, culture or DFA positive only

☐ A - PCR positive, subtype not done ☐ A - PCR positive, untypeable ☐ A (H3) ☐ A (2009 H1) ☐ 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 ≥37.8º ☐ Cough ☐ Sore throat

☐ Myalgia ☐ Nausea/vomiting ☐ Diarrhea

☐ Shortness of breath ☐O_2 sat __% on RA

☐ Altered mental status ☐ Seizures

☐ 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: _____

_____

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 so that we can assist with collection and shipment of specimens for further characterization.