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: _____

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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: _____