

Influenza Deaths

COUNTY

Date investigation initiated: ___/___/___

FOR STATE USE ONLY

 #

___/___/___ case report

- confirmed
 presumptive
 suspect

___/___/___ interstate

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City County Zip

Occupation _____

SOURCES OF REPORT (check all that apply)

- Lab Infection Control Practitioner
 Physician _____

Name _____

Phone _____ Date ___/___/___
(first report)

Primary M.D. _____

Phone _____

DEMOGRAPHICS

SEX

- female male

DATE OF BIRTH ___/___/___
m d y

or, if unknown, AGE _____

HISPANIC yes no unknown

RACE

- White American Indian
 Black Asian
 unknown Pacific Islander
 other _____

ILLNESS AND DEATH INFORMATION

Date of onset ___/___/___ Date of death ___/___/___
m d y m d y

Location of death

- outside hospital emergency department inpatient ward
 ICU
 other, specify _____

If hospitalized, admit date ___/___/___

TESTING

Test	Influenza A H1 (seasonal)	Influenza A H3 (seasonal)	Influenza A H1N1 (pandemic)	Influenza A (unsubtypable)	Influenza A (not subtyped)	Influenza B	Influenza (unknown type)	Date of collection	Specimen type	Lab where tested
Rapid test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____	_____
PCR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____	_____
Culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____	_____
DFA/IFA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____	_____
Serology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____	_____
Immuno-histo chemical stain (autopsy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____	_____
Unspecified test type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____	_____

VACCINATIONS

Current seasonal vaccine administered before illness onset? yes no unk

If yes, date dose 1 ___/___/___ date dose 2 ___/___/___ (if applicable)

If yes, specify type:

- Trivalent inactivated influenza vaccine (TIV) [injected]
 Live-attenuated influenza vaccine (LAIV) [nasal spray]
 Unknown

H1N1 vaccine administered before illness onset? yes no unk

If yes, date dose 1 ___/___/___ date dose 2 ___/___/___ (if applicable)

CULTURE CONFIRMATION OF BACTERIAL PATHOGENS

Was a specimen collected for bacterial culture? yes no unk

If yes, indicate sites(s):

Site	Collection Date m d y	Positive	Negative	Unknown	If positive, specify organism
<input type="checkbox"/> Blood	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Pleural fluid	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> CSF	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Sputum	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> ET Tube	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Other respiratory or sterile site _____	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

UNDERLYING MEDICAL CONDITIONS

Any underlying medical conditions that existed before the start of acute illness? yes no unk

If yes, check below:

- Developmental delay
- Metabolic disorder (including diabetes, specify) _____
- Cardiac disease (specify) _____
- Chronic pulmonary disease (specify) _____
- Pregnant (specify gestational age in weeks) _____
- Immunosuppressive condition (including chemotherapy or steroidal treatment, specify) _____
- Asthma or reactive airway disease _____
- Neuromuscular disorder (including cerebral palsy, specify) _____
- Obese (include BMI or weight and height, if available) _____
- Other (specify) _____

PEDIATRIC DEATHS--ADDITIONAL QUESTIONS

ONLY DEATHS OF THOSE 0–17 YEARS OF AGE

Did cardiac or respiratory arrest occur outside the hospital? yes no unk

Was an autopsy performed? yes no unk
if yes, where? _____

Are isolates or clinical specimens, including autopsy specimens or bacterial pathogens available to be sent to CDC? yes no unk
If yes, specify _____

Mechanical ventilation? yes no unk

Antiviral prophylaxis? yes no unk

If yes, type of antiviral medication:

	Start Date m d y		Start Date m d y
<input type="checkbox"/> Amantadine (Symmetrel)	___/___/___	<input type="checkbox"/> Oseltamavir (Tamiflu)	___/___/___
<input type="checkbox"/> Rimantadine (Flumadine)	___/___/___	<input type="checkbox"/> Other _____	___/___/___
<input type="checkbox"/> Zanamivir (Relenza)	___/___/___	<input type="checkbox"/> Unknown _____	___/___/___

Was the patient receiving the following therapies 7 days prior to illness onset or after illness onset?

Aspirin NSAID Antibiotic therapy (after onset only) specify _____

Did the patient receive influenza vaccine in *previous* seasons? yes no unk

If <8 years of age at time of death, did patient receive two doses of vaccine during *any* previous season? yes no unk

Check any complications that occurred during the acute illness:

<input type="checkbox"/> Pneumonia (chest x-ray confirmed)	<input type="checkbox"/> Acute Respiratory Disease Syndrome (ARDS)
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Encephalopathy or Encephalitis
<input type="checkbox"/> Croup	<input type="checkbox"/> Reye Syndrome
<input type="checkbox"/> Shock	<input type="checkbox"/> Sepsis
<input type="checkbox"/> Seizure	<input type="checkbox"/> Other, specify: _____
<input type="checkbox"/> Another viral co-infection, specify: _____	

COMMENTS:

ADMINISTRATION

Completed by _____ Date _____ Phone _____ Initial report sent to OHS on ___/___/___
Cause of death (ICD-10) _____ Case investigation sent to OHS on ___/___/___