

# Influenza-related Hospitalizations

COUNTY

Date investigation initiated: \_\_\_/\_\_\_/\_\_\_

FOR STATE USE ONLY

#

\_\_\_/\_\_\_/\_\_\_ case report

confirmed

presumptive

\_\_\_/\_\_\_/\_\_\_ interstate

suspect

## CASE IDENTIFICATION

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

Address \_\_\_\_\_  
Street City County Zip

SOURCES OF REPORT (check all that apply)

Lab  Infection Control Practitioner  
 Physician  \_\_\_\_\_

Name \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_  
(first report)

## 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 \_\_\_\_\_

## HOSPITAL DETAILS

Name of Hospital \_\_\_\_\_

date of admission \_\_\_/\_\_\_/\_\_\_  
m d y

Medical Record Number \_\_\_\_\_

## LABORATORY DATA

	Influenza A H1 (seasonal)	Influenza A H3 (seasonal)	Influenza A H1N1 (pandemic)	Influenza A (unsubtypable)	Influenza A (not subtyped)	Influenza B	Influenza A /B undifferentiated	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"/>	___/___/___	_____	_____
Unspecified test type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____	_____

COMMENTS:

## ADMINISTRATION

August 2009

Completed by \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Initial report sent to OHS on \_\_\_/\_\_\_/\_\_\_

Case investigation sent to OHS on \_\_\_/\_\_\_/\_\_\_