



# Influenza-Associated Pediatric Deaths Case Report Form

Form approved  
OMB No. 0920-0004

## 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: _____ <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Years	6. Date of birth: _____/_____/_____ MM DD YYYY	7. Sex: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	8. Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
9. Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Unknown			

### Death Information

10. Date of illness onset: _____/_____/_____ MM DD YYYY	11. Date of death: _____/_____/_____ MM DD YYYY	12. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
13. Location of death: <input type="checkbox"/> Home <input type="checkbox"/> Emergency Dept (ER) <input type="checkbox"/> Inpatient ward <input type="checkbox"/> ICU <input type="checkbox"/> Other (specify): _____		

### Influenza Testing (check all that were used)

Test Type	Result	Specimen Collection Date
<input type="checkbox"/> Commercial rapid antigen test	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A/B (Not Distinguished)	____/____/____
<input type="checkbox"/> Viral culture	<input type="checkbox"/> Influenza A (Subtyping Not Done) <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A (Unable To Subtype) <input type="checkbox"/> Influenza A (H1) <input type="checkbox"/> Influenza A (H3)	____/____/____
<input type="checkbox"/> Direct fluorescent antibody (DFA)	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A/B	____/____/____
<input type="checkbox"/> Indirect fluorescent antibody (IFA)	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A/B	____/____/____
<input type="checkbox"/> Enzyme immunoassay (EIA)	<input type="checkbox"/> Influenza A (Subtyping Not Done) <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A (Unable To Subtype) <input type="checkbox"/> Influenza A (H1) <input type="checkbox"/> Influenza A (H3)	____/____/____
<input type="checkbox"/> RT-PCR	<input type="checkbox"/> Influenza A (Subtyping Not Done) <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A (Unable To Subtype) <input type="checkbox"/> Influenza A (H1) <input type="checkbox"/> Influenza A (H3)	____/____/____
<input type="checkbox"/> Immunohistochemistry (IHC)	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> <i>Streptococcus pneumoniae</i>	<input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin <b>sensitive</b>	<input type="checkbox"/> <i>Neisseria meningitidis</i> (serogroup, if known): _____
<input type="checkbox"/> <i>Haemophilus influenzae</i> type b	<input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin <b>resistant (MRSA)</b>	<input type="checkbox"/> Group A streptococcus
<input type="checkbox"/> <i>Haemophilus influenzae</i> not-type b	<input type="checkbox"/> <i>Staphylococcus aureus</i> , <b>sensitivity not done</b>	<input type="checkbox"/> Other invasive bacteria: _____

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-0004).



# Influenza-Associated Pediatric Deaths Case Report Form

## 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  Hemoglobinopathy (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)
- |                                      |   |   |   |
|--------------------------------------|---|---|---|
| <input type="checkbox"/> 1 dose ONLY | <input type="checkbox"/> <14 days prior to illness onset                    | Date dose given: _____ / _____ / _____              |   |
|                                      | <input type="checkbox"/> ≥14 days prior to illness onset                    | MM DD YYYY  |   |
| <input type="checkbox"/> 2 doses     | <input type="checkbox"/> 2 <sup>nd</sup> dose given <14 days prior to onset | Date of 1 <sup>st</sup> dose: _____ / _____ / _____ | Date of 2 <sup>nd</sup> dose: _____ / _____ / _____ |
|                                      | <input type="checkbox"/> 2 <sup>nd</sup> dose given ≥14 days prior to onset | MM DD YYYY  | 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: \_\_\_\_\_

**PLEASE FAX COPIES OF THIS FORM TO 1-800-232-1322 IF WEB APPLICATION IS NOT AVAILABLE**