



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)? Yes No

<input type="checkbox"/> <i>Streptococcus pneumoniae</i>	<input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin sensitive	<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 resistant (MRSA)	<input type="checkbox"/> Group A streptococcus
<input type="checkbox"/> <i>Haemophilus influenzae</i> not-type b	<input type="checkbox"/> <i>Staphylococcus aureus</i> , sensitivity not done	<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).



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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 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
<input type="checkbox"/> ≥14 days prior to illness onset | Date dose given: _____ / _____ / _____
MM DD YYYY | |
| <input type="checkbox"/> 2 doses | <input type="checkbox"/> 2 nd dose given <14 days prior to onset
<input type="checkbox"/> 2 nd dose given ≥14 days prior to onset | Date of 1 st dose: _____ / _____ / _____
MM DD YYYY | Date of 2 nd 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: _____

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