



**Instructions: Please provide the information below on all hospitalized and deceased patients with laboratory-confirmed influenza infection. Minimum required fields are underlined in BOLD font.**

# Influenza

County \_\_\_\_\_

## REPORT SOURCE

**Reporter type:**  Lab  Hospital  HCP  Public health agency  Other

**Reporter name:** \_\_\_\_\_

**Reporter phone:** \_\_\_\_\_

## PATIENT INFORMATION

**Name (last, first)** \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Medical Record #: \_\_\_\_\_

**Birth date** \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_

**Gender**  F  M  Other  Unk

**Ethnicity**  Hispanic or Latino  Unk  
 Not Hispanic or Latino

**Race** (check all that apply)  Unknown  
 Amer Ind/AK Native  Asian  
 Native HI/other PI  Black/Afr Amer  
 White  Other

## CLINICAL INFORMATION

**Onset date:** \_\_\_/\_\_\_/\_\_\_  Derived

### Predisposing Conditions

**Y N DK NA**

- Any current conditions such as:
- |  |   |
|--|---|
| <input type="checkbox"/> Smoker          | <input type="checkbox"/> Alcohol or drug abuse  |
| <input type="checkbox"/> Chemotherapy    | <input type="checkbox"/> Neuromuscular disease  |
| <input type="checkbox"/> Steroid therapy | <input type="checkbox"/> Organ transplant       |
| <input type="checkbox"/> HIV/AIDS        | <input type="checkbox"/> Chronic liver disease  |
| <input type="checkbox"/> Cancer past yr. | <input type="checkbox"/> Chronic heart disease  |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Chronic lung disease   |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Chronic kidney disease |
| <input type="checkbox"/> Cognitive abnl. | <input type="checkbox"/> Hemoglobinopathy       |
| <input type="checkbox"/> Obesity         | Ht: ___(in) Wt: ___(lbs)                        |
| <input type="checkbox"/> Other:          | _____   |

**Pregnant** if yes, weeks: \_\_\_\_\_  
outcome: \_\_\_\_\_

### Clinical Findings

**Y N DK NA**

- Acute respiratory distress syndrome  
    **Admitted to intensive care unit**  
    **Mechanical ventilation**  
    Treated with antiviral medications  
Type, dose: \_\_\_\_\_  
Dates started: \_\_\_/\_\_\_/\_\_\_

### Hospitalization

**Y N DK NA**

- Hospitalized for this illness**  
Hospital name \_\_\_\_\_  
Admit date \_\_\_/\_\_\_/\_\_\_ Discharge date \_\_\_/\_\_\_/\_\_\_  
    **Died from illness** Death date \_\_\_/\_\_\_/\_\_\_

### Vaccination

**Y N DK NA**

- Seasonal influenza vaccine this flu season Doses: \_\_\_  
Date(s) and type(s) e.g., shot, spray: \_\_\_\_\_  
    H1N1 swine vaccine this flu season Doses: \_\_\_  
Date(s) and type(s) e.g., shot, spray: \_\_\_\_\_

### Laboratory

P = Positive N = Negative I = Indeterminate  
O = Other NT = Not Tested

**P N I O NT**

- Blood culture  
Date: \_\_\_/\_\_\_/\_\_\_  
Result:  MRSA  MSSA  Strep  Haemophilus  
 Other

### Influenza test results:

**LHJ species/Organism:**  A  B  Unk  Other

**LHJ serotype/Serogroup:**

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> A 2009 H1N1 | <input type="checkbox"/> A H1                                 |
| <input type="checkbox"/> A H3        | <input type="checkbox"/> A H1N1 (other)                       |
| <input type="checkbox"/> A H3N2      | <input type="checkbox"/> A H5, avian                          |
| <input type="checkbox"/> Unknown     | <input type="checkbox"/> A, unknown, but <u>not</u> 2009 H1N1 |
| <input type="checkbox"/> other       | <input type="checkbox"/> pending                              |

### Exposure

**Y N DK NA**

- Is the patient a healthcare worker?  
    Congregate living or employment  
 Barracks  Corrections  Long term care  
 Dormitory  Boarding school  Camp  
 Shelter  Other: \_\_\_\_\_

## NOTES

To be completed by local health jurisdiction:

LHJ notification date \_\_\_/\_\_\_/\_\_\_ Investigation start date: \_\_\_/\_\_\_/\_\_\_

Local health jurisdiction \_\_\_\_\_ Investigator \_\_\_\_\_ Investigation complete date \_\_\_/\_\_\_/\_\_\_