Washington State Department of HEALTH

Influenza Death

County

Case name (last, first) _____

Birth date ___/___/___ Age at symptom onset _____ ☐ Years ☐ Months

Alternate name _____

Phone _____ Email _____

Address type ☐ Home ☐ Mailing ☐ Other ☐ Temporary ☐ Work

Street address _____

City/State/Zip/County _____

Residence type (incl. Homeless) _____ WA resident ☐ Yes ☐ No

ADMINISTRATIVE

Investigator _____ LHJ Case ID (optional) _____

LHJ notification date ___/___/___

Classification

☐ Classification pending ☐ Confirmed ☐ Investigation in progress ☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

Investigation status

☐ Complete ☐ Complete – not reportable to DOH ☐ Unable to complete Reason _____ ☐ In progress

Dates: **Investigation start** ___/___/__ Investigation complete ___/___/__ Record complete ___/___/__ **Case complete** ___/___/__

REPORT SOURCE

Initial report source _____ LHJ _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply) _____

DEMOGRAPHICS

Sex at birth: ☐ Female ☐ Male ☐ Other ☐ Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity ☐ Hispanic, Latino/a, Latinx ☐ Non-Hispanic, Latino/a, Latinx ☐ Patient declined to respond ☐ Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race ☐ Amer Ind/AK Native (***specify***: ☐ Amer Ind ***and/or*** ☐ AK Native) ☐ Asian ☐ Black or African American ☐ Native HI/Pacific Islander (***specify***: ☐ Native HI ***and/or*** ☐ Pacific Islander) ☐ White ☐ Patient declined to respond ☐ Unk

Additional race information:

☐ Afghan ☐ Afro-Caribbean ☐ Arab ☐ Asian Indian ☐ Bamar/Burman/Burmese ☐ Bangladeshi ☐ Bhutanese
☐ Central American ☐ Cham ☐ Chicano/a or Chicanx ☐ Chinese ☐ Congolese ☐ Cuban ☐ Dominican ☐ Egyptian
☐ Eritrean ☐ Ethiopian ☐ Fijian ☐ Filipino ☐ First Nations ☐ Guamanian or Chamorro ☐ Hmong/Mong
☐ Indigenous-Latino/a or Indigenous-Latinx ☐ Indonesian ☐ Iranian ☐ Iraqi ☐ Japanese ☐ Jordanian ☐ Karen
☐ Kenyan ☐ Khmer/Cambodian ☐ Korean ☐ Kuwaiti ☐ Lao ☐ Lebanese ☐ Malaysian ☐ Marshallese ☐ Mestizo
☐ Mexican/Mexican American ☐ Middle Eastern ☐ Mien ☐ Moroccan ☐ Nepalese ☐ North African ☐ Oromo
☐ Pakistani ☐ Puerto Rican ☐ Romanian/Rumanian ☐ Russian ☐ Samoan ☐ Saudi Arabian ☐ Somali
☐ South African ☐ South American ☐ Syrian ☐ Taiwanese ☐ Thai ☐ Tongan ☐ Ugandan ☐ Ukrainian
☐ Vietnamese ☐ Yemeni ☐ Other: _____

What is your (your childs) preferred language? Check one:

☐ Amharic ☐ Arabic ☐ Balochi/Baluchi ☐ Burmese ☐ Cantonese ☐ Chinese (unspecified) ☐ Chamorro ☐ Chuukese
☐ Dari ☐ English ☐ Farsi/Persian ☐ Fijian ☐ Filipino/Pilipino ☐ French ☐ German ☐ Hindi ☐ Hmong ☐ Japanese
☐ Karen ☐ Khmer/Cambodian ☐ Kinyarwanda ☐ Korean ☐ Kosraean ☐ Lao ☐ Mandarin ☐ Marshallese ☐ Mixteco
☐ Nepali ☐ Oromo ☐ Panjabi/Punjabi ☐ Pashto ☐ Portuguese ☐ Romanian/Rumanian ☐ Russian ☐ Samoan
☐ Sign languages ☐ Somali ☐ Spanish/Castilian ☐ Swahili/Kiswahili ☐ Tagalog ☐ Tamil ☐ Telugu ☐ Thai ☐ Tigrinya
☐ Ukrainian ☐ Urdu ☐ Vietnamese ☐ Other language: _____ ☐ Patient declined to respond ☐ Unknown

Interpreter needed ☐ Yes ☐ No ☐ Unk

Case Name _____ LHJ Case ID _____

EMPLOYMENT AND SCHOOL

Employed ☐ Yes ☐ No ☐ Unk Occupation _____ Industry _____
Employer _____ Work site _____ City _____

Student/Day care ☐ Yes ☐ No ☐ Unk
Type of school ☐ Preschool/day care ☐ K-12 ☐ College ☐ Graduate School ☐ Vocational ☐ Online ☐ Other
School name _____ School address _____
City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____
OK to talk to patient (If Later, provide date) ☐ Yes ☐ Later ___/___/___ ☐ Never
Date of interview attempt ___/___/___ ☐ Complete ☐ Partial ☐ Unable to reach ☐ Patient could not be interviewed
Alternate contact: ☐ Parent/Guardian ☐ Spouse/Partner ☐ Friend ☐ Other _____
Name _____ Phone _____

Outbreak related ☐ Yes ☐ No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Symptom Onset ___/___/___ ☐ Derived Diagnosis date ___/___/___
Is this case a pediatric flu death (case under age 18 years) ☐ Yes ☐ No ☐ Unk If yes, complete ALL sections of this form

Clinical Features and Complications

Y N Unk

☐ ☐ ☐ Any fever, subjective or measured Temp measured? ☐ Yes ☐ No Highest measured temp _____ºF
☐ ☐ ☐ Cough Onset date ___/___/___
☐ ☐ ☐ Croup
☐ ☐ ☐ Diarrhea *(3 or more loose stools within a 24 hour period)*
☐ ☐ ☐ Dyspnea (shortness of breath)
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Pharyngitis (sore throat)
☐ ☐ ☐ Pneumonia
Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider Only
Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Not tested ☐ Other _____
☐ ☐ ☐ Illness clinically compatible with influenza infection
☐ ☐ ☐ Seizure new with disease
☐ ☐ ☐ Acute respiratory distress syndrome (ARDS) Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider only
☐ ☐ ☐ Neurologic/neurodevelopmental disorder _____

Y N Unk

☐ ☐ ☐ Any other complication _____
☐ ☐ ☐ Another viral co-infection _____

Pediatric Death Only

Y N Unk

☐ ☐ ☐ Bronchiolitis
☐ ☐ ☐ Encephalitis or encephalomyelitis
☐ ☐ ☐ Hemorrhagic pneumonia/pneumonitis
☐ ☐ ☐ Myocarditis
☐ ☐ ☐ Reye syndrome
☐ ☐ ☐ Shock
☐ ☐ ☐ Sepsis syndrome
☐ ☐ ☐ Did cardiac/respiratory arrest occur outside the hospital

Predisposing Conditions

Y N Unk

☐ ☐ ☐ Alcohol or drug abuse
☐ ☐ ☐ Cancer diagnosis or treatment in 12 months prior to onset _____
☐ ☐ ☐ Cardiac disease/congenital heart disease
☐ ☐ ☐ Chronic kidney disease
☐ ☐ ☐ Chronic liver disease
☐ ☐ ☐ Chronic lung disease (e.g., COPD, emphysema)
☐ ☐ ☐ Current tobacco smoker
☐ ☐ ☐ Diabetes mellitus
☐ ☐ ☐ HIV positive/AIDS
☐ ☐ ☐ Non-cancer immunosuppressive condition
☐ ☐ ☐ Chemotherapy
☐ ☐ ☐ Steroid therapy
☐ ☐ ☐ Cognitive abnormality
☐ ☐ ☐ Obesity Height (in inches) _____ Weight (in pounds) _____
☐ ☐ ☐ Organ transplant
☐ ☐ ☐ Other immunosuppressive condition _____
☐ ☐ ☐ Neuromuscular disorder (e.g., muscular dystrophy) _____
☐ ☐ ☐ Other underlying medical conditions _____

Pediatric Death Only

Y N Unk

☐ ☐ ☐ Asthma/reactive airway disease
☐ ☐ ☐ Hemoglobinopathy (e.g., sickle cell disease)
☐ ☐ ☐ Cerebral palsy
☐ ☐ ☐ Cystic fibrosis
☐ ☐ ☐ Moderate to severe developmental delay
☐ ☐ ☐ History of febrile seizures
☐ ☐ ☐ Chromosomal abnormality/genetic syndrome _____
☐ ☐ ☐ Antiviral prophylaxis
☐ ☐ ☐ Chronic aspirin therapy
☐ ☐ ☐ Chemotherapy or radiation therapy
☐ ☐ ☐ Steroids by mouth of injection
☐ ☐ ☐ Other immunosuppressive therapy _____
☐ ☐ ☐ History of seizures
☐ ☐ ☐ Mitochondrial disorder _____
☐ ☐ ☐ Premature at birth Gestational age in weeks _____
☐ ☐ ☐ Skin or soft tissue infection
☐ ☐ ☐ Endocrine disorder _____
☐ ☐ ☐ Other neurological disorder _____

Pregnancy

Pregnancy status at time of symptom onset

☐ Pregnant Weeks pregnant at any symptom onset _____
Outcome of pregnancy ☐ Still pregnant ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other _____
☐ Delivered – full term ☐ Delivered – preemie ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk

☐ Postpartum
Outcome of pregnancy ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other _____
☐ Delivered – full term ☐ Delivered – preemie ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk

☐ Neither pregnant nor postpartum ☐ Unk

Vaccination

Y N Unk

☐ ☐ ☐ Influenza vaccine during the current season (before illness)

First dose date ☐ Less than 14 days prior to illness onset ☐ Fourteen or more days prior to illness onset
Vaccine type ☐ Inactivated influenza vaccine (IIV3) [injected] ☐ Quadrivalent inactivated influenza vaccine (IIV4) [injected]
☐ Live-attenuated influenza vaccine (LAIV4) [nasal spray] ☐ Unk

Second dose date ☐ Less than 14 days prior to illness onset ☐ Fourteen or more days prior to illness onset ☐ Not given
Vaccine type ☐ Inactivated influenza vaccine (IIV3) [injected] ☐ Quadrivalent inactivated influenza vaccine (IIV4) [injected]
☐ Live-attenuated influenza vaccine (LAIV4) [nasal spray] ☐ Unk

Vaccine information available ☐ Yes ☐ No Date of vaccine administration ___/___/___
Vaccine lot number _____ Administering provider _____

Sources reviewed (check all the apply) ☐ Patient's immunization record ☐ Medical records ☐ Coroner's report
☐ Immunization information system (registry) ☐ Parent report ☐ News/media report
☐ Other _____

Pediatric Death Only

Y N Unk

☐ ☐ ☐ Influenza vaccine in previous season
☐ ☐ ☐ Received 2 doses of vaccine during a previous season (if patient was less than 8 years of age at the time of death)

Clinical Testing - *Pediatric Death Only*

Y N Unk

☐ ☐ ☐ Pathology specimens sent to CDCs Infectious Disease Pathology Branch Lab ID _____
☐ ☐ ☐ Influenza isolates or original clinical material sent to CDCs Influenza Division Lab ID _____
☐ ☐ ☐ Were other respiratory specimens collected for bacterial culture (e.g., sputum, ET tube aspirate) Specify _____
☐ ☐ ☐ Was a specimen collected for bacterial culture from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid? *Specimens collected greater than 24 hours after death are not sterile*

Hospitalization

Y N Unk

☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name _____
Hospital admission date ___/___/___ Discharge ___/___/___
☐ ☐ ☐ Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
☐ ☐ ☐ Mechanical ventilation or intubation required

Y N Unk

☐ ☐ ☐ **Died of this illness** Death date ___/___/___ *Please fill in the death date information on the Person Screen*
☐ ☐ ☐ Autopsy performed
☐ ☐ ☐ Specimens available
☐ ☐ ☐ Was a specimen (e.g., fixed lung tissue) collected from an autopsy for testing of bacterial pathogens by a local or state pathologist?
☐ ☐ ☐ Death certificate lists disease as a cause of death or a significant contributing condition
☐ ☐ ☐ Health care visit prior to death
Location of death ☐ Outside of hospital (e.g., home or in transit to the hospital
☐ Emergency department (ED) ☐ Inpatient ward ☐ ICU
☐ Other _____

RISK AND RESPONSE (Ask about exposures 1-7 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____
Destination name			
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Risk and Exposure Information

Y N Unk

☐ ☐ ☐ Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country _____
☐ ☐ ☐ Antiviral therapy received after illness onset _____
☐ ☐ ☐ (Potential) Occupational exposure

Exposure and Transmission Summary

Likely geographic region of exposure ☐ In Washington – county _____ ☐ Other state _____
☐ Not in US - country _____ ☐ Unk

International travel related ☐ During entire exposure period ☐ During part of exposure period ☐ No international travel

Suspected exposure setting ☐ Day care/Childcare ☐ School (not college) ☐ Doctor's office ☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient facility ☐ Home ☐ Work ☐ College ☐ Military ☐ Correctional facility ☐ Place of worship
☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter ☐ International travel ☐ Out of state travel ☐ Transit
☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Hotel/motel/hostel ☐ Other _____
Describe _____

Exposure summary

Case Name _____ LHJ Case ID _____

Suspected transmission setting (check all that apply) ☐ Day care/Childcare ☐ School (not college) ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER ☐ Hospital outpatient facility ☐ Home ☐ Work ☐ College ☐ Military
☐ Correctional facility ☐ Place of worship ☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter
☐ International travel ☐ Out of state travel ☐ Transit ☐ Social event ☐ Large public gathering ☐ Restaurant
☐ Hotel/motel/hostel ☐ Other _____
Describe _____

Public Health Interventions/Actions

Y N Unk

☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___
☐ ☐ ☐ Any other public health action _____

TREATMENT

Did patient receive prophylaxis/treatment ☐ Yes ☐ No ☐ Unk
Specify antiviral _____
Prescribed dose _____ ☐ g ☐ mg ☐ ml Frequency _____ Duration _____ ☐ Days ☐ Weeks ☐ Months

NOTES

LAB RESULTS

Lab report information
Lab report reviewed – LHJ ☐
WDRS user-entered lab report note

Submitter _____
Performing lab for entire report _____
Referring lab _____

Specimen
Specimen identifier/accession number _____
Specimen collection date ___/___/___ Specimen received date ___/___/___
WDRS specimen type _____
WDRS specimen source site _____
WDRS specimen reject reason _____

Test performed and result
WDRS test performed _____
WDRS test result, coded _____
WDRS test result, comparator _____
WDRS result, numeric only (enter only if given, including as necessary ***Comparator*** and ***Unit of measure***) _____
WDRS unit of measure _____
Test method _____
WDRS interpretation code _____
Test result – Other, specify _____
WDRS result summary ☐ Positive ☐ Negative ☐ Indeterminate ☐ Equivocal ☐ Test not performed ☐ Pending
Test result status ☐ Final results; Can only be changed with a corrected result
☐ Preliminary results
☐ Record coming over is a correction and thus replaces a final result
☐ Results cannot be obtained for this observation
☐ Specimen in lab; results pending
Result date ___/___/___
Upload document

Ordering Provider
WDRS ordering provider _____

Ordering facility
WDRS ordering facility name _____

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.