Swine Influenza: Clinical Description of Hospitalized Patients

(FAX to: 404-248-4094 or email to casereportforms@cdc.gov)

State EPI ID # (epidemiology ID) _____ CDC EPI ID # _____

State lab specimen ID #1 _____ CDC lab specimen ID #1 _____

State lab specimen ID #2 _____ CDC lab specimen ID #2 _____

CDC (lab) unique ID # _____

CDC contacts: **1. Influenza Division, ask for medical epidemiologist** **Voice: 404.639.3591**

2. Director's Emergency Operation Center **Voice: 404.639.3747 (daytime)**
770.488.7100 (after hours)

If a cluster of pandemic influenza/novel influenza A human cases occurs, the available contacts will likely change, but the above are provide as initial contacts until a response network is established.

Primary health department contact or study investigator

Name and Position: _____

Institution: _____

City: _____ State/Country: _____ Zip _____

Phone: (_____)_____ - _____ Pager: (_____)_____ - _____

Fax: (_____)_____ - _____ Email: _____

Case enrollment information

Last Name:	First Name:	Middle Name:	Patient's initials:	Last 4-digits SSN**:
_____	_____	_____	_____	_____

Address:	City:	Phone No.:
_____	_____	(_____)_____ - _____

County of residence:	State of residence: (use 2-letter abbr)	Zip:	Country, if not US:
_____	____ ____	_____	_____

If a residential address is not available, GIS coordinates of residence: _____Lat x _____ Long
(Latitude Degrees/Minutes/Seconds X Longitudinal Degrees/Minutes/Seconds)

Date of Birth:	Sex:	Ethnicity:	Race (**check all that apply**):
_____-_____-_____ (MM-DD-YYYY) Age: _____ ☐ mo ☐ yrs	☐ Male ☐ Female	☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Not Specified	☐ White ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Multiracial ☐ Not Specified

* Contact with CDC should occur before data collection begins so that the CDC ID series can be established. Depending on the State ID, one or two case IDs will be used.

** Social Security Number

☐ Data not transmitted

Notes:

Medical Care Facility Identification	**STATE ID #:** _____	**CDC ID#:** _____

A. Clinic/Hospital Name: _____ Phone: (_____) _____-_____

Fax: (_____) _____-_____

Date of visit: _____/ _____/ _____ Patient or Medical Record #: _____

Admitted? ☐ Yes ☐ No

Admission date*: _____/ _____/ _____ Was the patient transferred? ☐ Yes, list facility below as B (discharge date for A = admit date B) ☐ No

Discharge date: _____/ _____/ _____

Treating Physician Name: _____ Pager/cell: (_____) _____-_____ Clinic: (_____) _____-_____

B. Clinic/Hospital Name: _____ Phone: (_____) _____-_____

Fax: (_____) _____-_____

Date of visit: _____/ _____/ _____ Patient or Medical Record #: _____

Admitted? ☐ Yes ☐ No

Admission date*: _____/ _____/ _____ Was the patient transferred? ☐ Yes, list facility below as C. (discharge date for B = admit date C) ☐ No

Discharge date: _____/ _____/ _____

Treating Physician Name: _____ Pager/cell: (_____) _____-_____ Clinic: (_____) _____-_____

C. Clinic/Hospital Name: _____ Phone: (_____) _____-_____

Fax: (_____) _____-_____

Date of visit: _____/ _____/ _____ Patient or Medical Record #: _____

Admitted? ☐ Yes ☐ No

Admission date*: _____/ _____/ _____ Discharge date: _____/ _____/ _____

Treating Physician Name: _____ Pager/cell: (_____) _____-_____ Clinic: (_____) _____-_____

*If admitted to the hospital on date other than visit date, list admission date.

Vaccination History	**STATE ID #:** _____	**CDC ID#:** _____

1. Did the patient receive any **influenza vaccine** during fall or winter of the current influenza season? ☐ Yes ☐ No ☐ Unknown

If **YES,** please specify vaccine type:	Date of receipt Dose 1	Dose 2
☐ *Injected* vaccine --Trivalent inactivated influenza vaccine (TIV)	____/_____/_____ ☐ Unknown	____/_____/_____ ☐ Unknown
☐ *Nasal spray* -- Live-attenuated influenza vaccine (LAIV)	____/_____/_____ ☐ Unknown	____/_____/_____ ☐ Unknown
☐ Unknown	mm/dd/yy	mm/dd/yy

2. Did the patient receive any **novel influenza vaccine, swine H1N1**?

☐ Yes ☐ No ☐ Unknown

If **YES,** please specify all vaccine received: Indicate whether 1 or 2 doses were received by completing date of receipt for each dose

☐ Sanofi Pasteur xx vaccine	Dose #1	____/_____/_____ mm/dd/yy	OR	____/_____ mm/yy	☐ Unknown
	Dose #2	____/_____/_____ mm/dd/yy		____/_____ mm/yy	☐ Unknwon
☐ GlaxoSmithKline *xx* vaccine	Dose #1	____/_____/_____ mm/dd/yy	OR	____/_____ mm/yy	☐ Unknown
	Dose #2	____/_____/_____ mm/dd/yy		____/_____ mm/yy	☐ Unknwon
☐ Chiron xx vaccine	Dose #1	____/_____/_____ mm/dd/yy	OR	____/_____ mm/yy	☐ Unknown
	Dose #2	____/_____/_____ mm/dd/yy		____/_____ mm/yy	☐ Unknwon
☐ Other vaccine Specify:_____	Dose #1	____/_____/_____ mm/dd/yy	OR	____/_____ mm/yy	☐ Unknown
	Dose #2	____/_____/_____ mm/dd/yy		____/_____ mm/yy	☐ Unknwon
☐ Unknown	Dose #1	____/_____/_____ mm/dd/yy	OR	____/_____ mm/yy	☐ Unknown
	Dose #2	____/_____/_____ mm/dd/yy		____/_____ mm/yy	☐ Unknwon

3. Did the patient ever receive **pneumococcal vaccine?** ☐ Yes ☐ No ☐ Unknown

If **YES,** in what year was pneumococcal vaccine received? _____

What type of vaccine? ☐ 7-valent conjugate ☐ 23-valent polysaccharide ☐ Unknown

Past medical history	**STATE ID #:** _____	**CDC ID#:** _____

1. Currently smoke cigarettes? ☐ Everyday ☐ Some days ☐ Not at all

   If **YES,** how many years as a smoker? _____ yrs

Has the person ever been diagnosed with:

1. Cognitive dysfunction ☐ Yes ☐ No ☐ Unknown

   If **YES**, specify by checking all that apply : ☐ Down's syndrome ☐ dementia ☐ Other _____

2. Seizure disorder ☐ Yes ☐ No ☐ Unknown

3. Neuromuscular disorder ☐ Yes ☐ No ☐ Unknown

   If **YES**, specify by checking all that apply ☐ cerebral palsy ☐ history of stroke ☐ Other _____

4. Guillain-Barre Syndrome ☐ Yes ☐ No ☐ Unknown

5. Chronic lung disease ☐ Yes ☐ No ☐ Unknown

   If **YES**, specify by checking all that apply ☐ asthma ☐ cystic fibrosis ☐ COPD ☐ Other _____

6. Chronic metabolic disorders, including diabetes mellitus ☐ Yes ☐ No ☐ Unknown

7. Chronic cardiovascular disease, excluding hypertension ☐ Yes ☐ No ☐ Unknown

   If **YES**, specify . . . . . _____

8. Hemoglobinopathy, including sickle cell disease ☐ Yes ☐ No ☐ Unknown

9. Renal disease ☐ Yes ☐ No ☐ Unknown

   If **YES**, specify . . . . . _____

10. Cancer diagnosed in last year, including leukemia/lymphoma (excluding: nonmelanoma skin cancer) ☐ Yes ☐ No ☐ Unknown

11. Immunosuppressive condition*, including chemotherapy, steroid ☐ Yes ☐ No ☐ Unknown

    If **YES**, specify condition and/or medication _____

12. Pregnant, currently or within 10 days of hospitalization ☐ Yes ☐ No ☐ Unknown

    If **YES**, specify Expected Date of Confinement (EDC) or delivery date: _____/____/_____

13. Other condition. Specify: _____

14. Other condition. Specify: _____

15. Other condition. Specify: _____

16. Other condition. Specify: _____

*condition active at the time of illness

Clinical Signs and Symptoms	**STATE ID #: _____**	**CDC ID#: _____**

Describe the patient's clinical course over time, from onset of symptoms to seeking care, at initial presentation for care and finally at presentation when admitted for hospitalization

Symptoms	**Initial Onset** Date (mm/dd/yyyy)	**Initial Presentation for Care** ____/_____/_____ mm/dd/yyyy	**Presentation at Hospital Admission** (if presentation for care=hospital admission, check ☐ and do NOT recopy symptoms in this column) ____/_____/_____ mm/dd/yyyy
1. Fever subjective	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
measured temperature: _____	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
2. Chills	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
3. Fatigue/weakness	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
4. Headache	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
5. Altered mental status	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
6. Seizure	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
7. Red or draining eyes (conjunctivitis)	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
8. Runny nose (rhinorrhea)	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
9. Nasal congestion	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
10. Sore throat	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
11. Cough	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
With sputum production	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Hemoptysis or bloody sputum	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
12. Wheezing	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
13. Sneezing	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
14. Shortness of breath/difficulty breathing	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
15. Chest pain	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
16. Abdominal pain	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
17. Vomiting	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
18. Diarrhea	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
19. Muscle aches (myalgias)	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Of lower leg (calf muscles)	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
20. Other (specify)_____	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
21. Other (specify)_____	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
22. Other (specify)_____	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
23. Other (specify)_____	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
24. Other (specify)_____	☐ Yes ☐ No ____/_____/_____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Vital Signs – Hospitalization	**STATE ID #: _____**	**CDC ID#: _____**

Please note the following vital signs at hospital admission presentation and during the first 7 days of hospitalization.
Document the date measured fever (temp >38.0°C or 100.4°F) resolved:

	At presentation	**During first 7 days of hospitalization**							**Resolution of fever**
		Day 1	*Day 2*	*Day 3*	*Day 4*	*Day 5*	*Day 6*	*Day 7*	
Date(s) taken: (mm/dd/yy)	____/____/_____	____/____/_____	____/____/_____	____/____/_____	____/____/_____	____/____/_____	____/____/_____	____/____/_____	____/____/_____
1. Max Temperature (Tmax)	____ ° C	____ ° C	____ ° C	____ ° C	____ ° C	____ ° C	____ ° C	____ ° C	____ ° C
2. Lowest Blood pressure (BP)	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____	____ / ____	
3. Extreme* Respiratory rate	_____ per min	_____ per min	_____ per min	_____ per min	_____ per min	_____ per min	_____ per min	_____ per min	
4. Extreme* Heart rate	_____ beats/min	_____ beats/min	_____ beats/min	_____ beats/min	_____ beats/min	_____ beats/min	_____ beats/min	_____ beats/min	
		Using: □ O_2 mask □ ventilator	Using: □ O_2 mask □ ventilator	Using: □ O_2 mask □ ventilator	Using: □ O_2 mask □ ventilator	Using: □ O_2 mask □ ventilator	Using: □ O_2 mask □ ventilator	Using: □ O_2 mask □ ventilator	
5. O_2 Sat (lowest)	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %	
6. Fi O_2[†]	_____	_____	_____	_____	_____	_____	_____	_____	
7. Glucose, serum	_____ mg/dl								
8. Height	_____ *Circle:* cm or inches								
9. Weight	_____ *Circle:* kg or lbs								

* highest or lowest
[†]fraction of inspired oxygen

Hematology and Serum Chemistries	**STATE ID #: _____**	**CDC ID #: _____**

Note initial value and any significant changes that occurred at hospital admission presentation and during hospitalization

	At presentation	**During hospitalization --extreme* values**			
		1st week	*2nd week*	*3rd week*	*At hospital discharge***
Date (mm/dd/yy):	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
1. White blood cell count (WBC)	_____cells/mm^3	_____cells/mm^3	_____cells/mm^3	_____cells/mm^3	_____cells/mm^3
2. Differential: Neutrophils	_____%	_____%	_____%	_____%	_____%
Bands	_____%	_____%	_____%	_____%	_____%
Lymphocytes	_____%	_____%	_____%	_____%	_____%
Eosinophils	_____%	_____%	_____%	_____%	_____%
3. Hematocrit (Hct)	_____%	_____%	_____%	_____%	_____%
4. Platelets (Plt)	_____10^3/mm^3	_____10^3/mm^3	_____10^3/mm^3	_____10^3/mm^3	_____10^3/mm^3
5. Prothrombin time (PT)	_____sec	_____sec	_____sec	_____sec	_____sec
6. INR	_____	_____	_____	_____	_____
7. Sodium (Na)	_____U/L	_____U/L	_____U/L	_____U/L	_____U/L
8. Potassium (K)	_____U/L	_____U/L	_____U/L	_____U/L	_____U/L
9. Bicarbonate (HCO_3)	_____U/L	_____U/L	_____U/L	_____U/L	_____U/L
10. Serum albumin	_____g/dL	_____g/dL	_____g/dL	_____g/dL	_____g/dL
11. Serum creatinine	_____mg/dL	_____mg/dL	_____mg/dL	_____mg/dL	_____mg/dL
12. Serum glucose		_____mg/dL	_____mg/dL	_____mg/dL	_____mg/dL
13. SGPT/ALT	_____U/L	_____U/L	_____U/L	_____U/L	_____U/L
14. SGOT/AST	_____U/L	_____U/L	_____U/L	_____U/L	_____U/L
15. Total bilirubin	_____mg/dL	_____mg/dL	_____mg/dL	_____mg/dL	_____mg/dL
16. Serum ammonia	_____mcg/dL	_____mcg/dL	_____mcg/dL	_____mcg/dL	_____mcg/dL
17. Lactate dehydrogenase (LDH)	_____U/L	_____U/L	_____U/L	_____U/L	_____U/L
18. Lipase	_____U/L	_____U/L	_____U/L	_____U/L	_____U/L
19. Creatine kinase (CK or CPK)	_____U/L	_____U/L	_____U/L	_____U/L	_____U/L
20. C-reactive protein (CRP)	_____mg/dL	_____mg/dL	_____mg/dL	_____mg/dL	_____mg/dL
21. Erythrocyte sedimentation rate (ESR)	_____mg/dL	_____mg/dL	_____mg/dL	_____mg/dL	_____mg/dL
22. _____	_____Units:____	_____Units:____	_____Units:____	_____Units:____	_____Units:____
23. _____	_____Units:____	_____Units:____	_____Units:____	_____Units:____	_____Units:____
24. _____	_____Units:____	_____Units:____	_____Units:____	_____Units:____	_____Units:____

Other significant lab findings (e.g., CSF protein)

Type of test	Specimen type	Date (mm/dd/yy)	Result
		_____/_____/_____	
		_____/_____/_____	
		_____/_____/_____	

* highest or lowest

** discharge from hospital or at death

Radiology — Chest x-ray	**STATE ID #:** _____	**CDC ID #:** _____

Note pulmonary radiologic findings at hospital admission presentation and during hospitalization. Other noteworthy radiologic images or reports should be shared with CDC on a case by case basis.

AT PRESENTATION

1. Did the patient have a **chest x-ray** …… ☐ Yes ☐ No ☐ Unknown

→ If YES, Date of first chest x-ray…… _____/ _____/ _____ (mm/dd/yy)

→ Any abnormal findings…….. ☐ Yes ☐ No ☐ Unknown

→ Check all that apply:

☐ Single lobar infiltrate	☐ Multi-lobar infiltrate	☐ Complete opacification	☐ Interstitial infiltrate
☐ Pneumothorax	☐ Pneumomediastium	☐ Widened mediastinum	☐ Hilar adenopathy
☐ Enlarged epiglottis	☐ Tracheal narrowing	☐ Pulmonary cavity or blebs	☐ Consolidation
☐ Enlarged heart	☐ Pleural effusion	☐ Granuloma	

→ Check all areas/regions with any abnormality:

☐ Left upper lobe	☐ Left lingula	☐ Left lower lobe
☐ Right upper lobe	☐ Right middle lobe	☐ Right lower lobe

→ Are any of the findings consistent with the pt's pre-existing medical history? ☐ Yes ☐ No ☐ Unknown

If YES, please explain.

→ Summarize impression (Please note if findings are new or consistent with pre-existing medical history):

Will a digital image of this chest x-ray be sent to CDC? ☐ Yes (see instruction below) ☐ No

Digital radiologic images that will be shared with CDC should be scanned as a jpg image. Patient's name and other personal identifying information should be hidden or blacked out. Digital image file name should include CDC ID and date of exam as a string. For example: 05100021007, where CDC ID=05100 and date of exam=021007 (February 10, 2007).

2. Did the patient have another chest x-ray with significantly different findings…… ☐ Yes ☐ No ☐ Unknown

→ If YES, Date of chest x-ray…… _____/ _____/ _____ (mm/dd/yy)

→ Any abnormal findings…….. ☐ Yes ☐ No ☐ Unknown

→ Check all that apply:

☐ Single lobar infiltrate	☐ Multi-lobar infiltrate	☐ Complete opacification	☐ Interstitial infiltrate
☐ Pneumothorax	☐ Pneumomediastium	☐ Widened mediastinum	☐ Hilar adenopathy
☐ Enlarged epiglottis	☐ Tracheal narrowing	☐ Pulmonary cavity or blebs	☐ Consolidation
☐ Enlarged heart	☐ Pleural effusion	☐ Granuloma	

→ Check all area/regions with any abnormality:

☐ Left upper lobe	☐ Left lingula	☐ Left lower lobe
☐ Right upper lobe	☐ Right middle lobe	☐ Right lower lobe

→ Summarize impression:

Will a digital image of this chest x-ray be sent to CDC? ☐ Yes (see instruction below) ☐ No

Digital radiologic images that will be shared with CDC should be scanned as a jpg image. Patient's name and other personal identifying information should be hidden or blacked out. Digital image file name should include CDC ID and date of exam as a string. For example: 05100021007, where CDC ID=05100 and date of exam=021007 (February 10, 2007.)

Radiology — Chest x-ray (continued)	**STATE ID #:** _____	**CDC ID #:** _____

Note pulmonary radiologic findings at hospital admission presentation and during hospitalization. Other noteworthy radiologic images or reports should be shared with CDC on a case by case basis.

3. Did the patient have another chest x-ray with significantly different findings…… ☐ Yes ☐ No ☐ Unknown

→ If YES, Date of chest x-ray……. _____/ _____/ _____ (mm/dd/yy)

→ Any abnormal findings……..…... ☐ Yes ☐ No ☐ Unknown

→ Check all that apply:

☐ Single lobar infiltrate	☐ Multi-lobar infiltrate	☐ Complete opacification	☐ Interstitial infiltrate
☐ Pneumothorax	☐ Pneumomediastium	☐ Widened mediastinum	☐ Hilar adenopathy
☐ Enlarged epiglottis	☐ Tracheal narrowing	☐ Pulmonary cavity or blebs	☐ Consolidation
☐ Enlarged heart	☐ Pleural effusion	☐ Granuloma	

→ Check all areas/regions with any abnormality:

☐ Left upper lobe	☐ Left lingula	☐ Left lower lobe
☐ Right upper lobe	☐ Right middle lobe	☐ Right lower lobe

→ Summarize impression:

Will a digital image of this chest x-ray be sent to CDC? ☐ Yes (see instruction below) ☐ No

Digital radiologic images that will be shared with CDC should be scanned as a jpg image. Patient's name and other personal identifying information should be hidden or blacked out. Digital image file name should include CDC ID and date of exam as a string. For example: 05100021007, where CDC ID=05100 and date of exam=021007 (February 10, 2007).

LAST CHEST XRAY

Last Chest x-ray prior to discharge or death

4. Did the patient have another chest x-ray with significantly different findings…… ☐ Yes ☐ No ☐ Unknown

→ If YES, Date of chest x-ray……. _____/ _____/ _____ (mm/dd/yy)

→ Any abnormal findings……..…... ☐ Yes ☐ No ☐ Unknown

→ Check all that apply:

☐ Single lobar infiltrate	☐ Multi-lobar infiltrate	☐ Complete opacification	☐ Interstitial infiltrate
☐ Pneumothorax	☐ Pneumomediastium	☐ Widened mediastinum	☐ Hilar adenopathy
☐ Enlarged epiglottis	☐ Tracheal narrowing	☐ Pulmonary cavity or blebs	☐ Consolidation
☐ Enlarged heart	☐ Pleural effusion	☐ Granuloma	

→ Check all areas/regions with any abnormality:

☐ Left upper lobe	☐ Left lingula	☐ Left lower lobe
☐ Right upper lobe	☐ Right middle lobe	☐ Right lower lobe

→ Summarize impression:

Will a digital image of this chest x-ray be sent to CDC? ☐ Yes (see instruction below) ☐ No

Digital radiologic images that will be shared with CDC should be scanned as a jpg image. Patient's name and other personal identifying information should be hidden or blacked out. Digital image file name should include CDC ID and date of exam as a string. For example: 05100021007, where CDC ID=05100 and date of exam=021007 (February 10, 2007).

Radiology — Chest CT or MRI	**STATE ID #:** _____	**CDC ID#:** _____

Note pulmonary radiologic findings at hospital admission presentation and during hospitalization. Other noteworthy radiologic images or reports should be shared with CDC on a case by case basis.

1. Did the patient have a **CT/MRI scan**?..... ☐ Yes ☐ No ☐ Unknown

→ If YES, Select one: ☐ CT- contrast ☐ CT- non contrast ☐ MRI

Date…… _____/ _____/ _____ (mm/dd/yy)

→ Any abnormal findings…….…….. ☐ Yes ☐ No ☐ Unknown

→ Check all that apply:

☐ Single lobar infiltrate	☐ Multi-lobar infiltrate	☐ Complete opacification	☐ Interstitial infiltrate
☐ Pneumothorax	☐ Pneumomediastium	☐ Widened mediastinum	☐ Hilar adenopathy
☐ Enlarged epiglottis	☐ Tracheal narrowing	☐ Pulmonary cavity or blebs	☐ Granuloma
☐ Enlarged heart	☐ Pleural effusion	☐ Empyema	☐ Consolidation

→ Check all alveolar spaces with any abnormality:

☐ Left upper lobe	☐ Left lingula	☐ Left lower lobe
☐ Right upper lobe	☐ Right middle lobe	☐ Right lower lobe

→ Summarize impression (Include any pertinent non pulmonary findings):

Will a digital image of this CT/MRI be sent to CDC? ☐ Yes (see instruction below) ☐ No

Digital radiologic images that will be shared with CDC should be scanned as a jpg image. Patient's name and other personal identifying information should be hidden or blacked out. Digital image file name should include CDC ID and date of exam as a string. For example: 05100021007A, where CDC ID=05100 and date of exam=021007 (February 10, 2007) and "A" indicates additional radiologic exam from same patient, same day

2. Did the patient have a another **CT /MRI scan**?..... ☐ Yes ☐ No ☐ Unknown

→ If YES, Select one: ☐ CT- contrast ☐ CT- non contrast ☐ MRI

Date…….…. _____/ _____/ _____ (mm/dd/yy)

→ Any abnormal findings…….…….. ☐ Yes ☐ No ☐ Unknown

→ Check all that apply:

☐ Single lobar infiltrate	☐ Multi-lobar infiltrate	☐ Complete opacification	☐ Interstitial infiltrate
☐ Pneumothorax	☐ Pneumomediastium	☐ Widened mediastinum	☐ Hilar adenopathy
☐ Enlarged epiglottis	☐ Tracheal narrowing	☐ Pulmonary cavity or blebs	☐ Granuloma
☐ Enlarged heart	☐ Pleural effusion	☐ Empyema	☐ Consolidation

→ Check all alveolar spaces with any abnormality:

☐ Left upper lobe	☐ Left lingula	☐ Left lower lobe
☐ Right upper lobe	☐ Right middle lobe	☐ Right lower lobe

→ Summarize impression (Include any pertinent non pulmonary findings):

Will a digital image of this CT/MRI be sent to CDC? ☐ Yes (see instruction below) ☐ No

Digital radiologic images that will be shared with CDC should be scanned as a jpg image. Patient's name and other personal identifying information should be hidden or blacked out. Digital image file name should include CDC ID and date of exam as a string. For example: 05100021007B, where CDC ID=05100 and date of exam=021007 (February 10, 2007) and "B" indicates second additional radiologic exam from same patient, same day

Medications and Blood Products	**STATE ID #:** _____	**CDC ID #:** _____

List medications the case-patient was taking at time of hospital admission presentation and during hospitalization:

	At hospital presentation		During hospitalization		
1. Antivirals (influenza and other)	Date Start (mm/dd/yy)	Dosage	Date Start (mm/dd/yy)	Date stopped (mm/dd/yy)	Dosage
Oseltamivir (Tamiflu)	____/____/____	_____	____/____/____	____/____/____	_____
Zanamivir (Relenza)	____/____/____	_____	____/____/____	____/____/____	_____
Amantadine [not for first-line treatment]	____/____/____	_____	____/____/____	____/____/____	_____
Rimantadine [not for first-line treatment]	____/____/____	_____	____/____/____	____/____/____	_____
Other _____ □ PO □ _____	____/____/____	_____	____/____/____	____/____/____	_____
Other _____ □ PO □ _____	____/____/____	_____	____/____/____	____/____/____	_____
2. Antimicrobials (include antibacterial, antifungal or antiparasitic agents)	Date Start (mm/dd/yy)	Dosage	Date Start (mm/dd/yy)	Date stopped (mm/dd/yy)	Dosage
_____ □ PO □ IV □ IM		_____	____/____/____	____/____/____	_____
_____ □ PO □ IV □ IM	____/____/____	_____	____/____/____	____/____/____	_____
_____ □ PO □ IV □ IM	____/____/____	_____	____/____/____	____/____/____	_____
_____ □ PO □ IV □ IM	____/____/____	_____	____/____/____	____/____/____	_____
3. Steroids or other immune modulating medication	Date Start (mm/dd/yy)	Dosage	Date Start (mm/dd/yy)	Date stopped (mm/dd/yy)	Dosage
_____ □ PO □ IV □ IM	____/____/____	_____	____/____/____	____/____/____	_____
_____ □ PO □ IV □ IM	____/____/____	_____	____/____/____	____/____/____	_____
_____ □ PO □ IV □ IM	____/____/____	_____	____/____/____	____/____/____	_____
4. Other prescription medications*		Dosage	Date Start (mm/dd/yy)	Date stopped (mm/dd/yy)	Dosage
_____ □ PO □ IV □ IM		_____	____/____/____	____/____/____	_____
_____ □ PO □ IV □ IM		_____	____/____/____	____/____/____	_____
_____ □ PO □ IV □ IM		_____	____/____/____	____/____/____	_____
_____ □ PO □ IV □ IM		_____	____/____/____	____/____/____	_____
_____ □ PO □ IV □ IM		_____	____/____/____	____/____/____	_____
5. Over-the-counter medications**	Date Start (mm/dd/yy)	Dosage	Date Start (mm/dd/yy)	Date stopped (mm/dd/yy)	Dosage
_____ □ PO □ IV □ IM	____/____/____	_____	____/____/____	____/____/____	_____
_____ □ PO □ IV □ IM	____/____/____	_____	____/____/____	____/____/____	_____
_____ □ PO □ IV □ IM	____/____/____	_____	____/____/____	____/____/____	_____
_____ □ PO □ IV □ IM	____/____/____	_____	____/____/____	____/____/____	_____
6. Herbal/non traditional medications	Date Start (mm/dd/yy)	Dosage	Date Start (mm/dd/yy)	Date stopped (mm/dd/yy)	Dosage
_____ □ PO □ IV □ IM	____/____/____	_____	____/____/____	____/____/____	_____
_____ □ PO □ IV □ IM	____/____/____	_____	____/____/____	____/____/____	_____
_____ □ PO □ IV □ IM	____/____/____	_____	____/____/____	____/____/____	_____
_____ □ PO □ IV □ IM	____/____/____	_____	____/____/____	____/____/____	_____

* medications taken on an on-going or chronic basis

** include aspirin, bismuth subsalicylate (Pepto Bismol), ibuprofen, acetaminophen, etc.

Influenza Diagnostic Testing	**STATE ID #:** ________________	**CDC ID#:** ________________

If any influenza culture, antibody tests, antigen detection, PCR or special stains were performed, please note results:

Specimen Type*	Collection Date mm/dd/yy	Test Performed	Results	Interpretation	Laboratory Name**
	____/____/____	☐ DFA/IFA ☐ rapid test ☐ PCR ☐ immunohistochem ☐ viral culture ☐ ____________ ☐ HI	☐ flu A ☐ flu B ☐ flu A/H1 ☐ flu A/H3 ☐ flu A unsubtypable ☐ flu A swine H1	☐ Positive ☐ Negative ☐ Indeterminate	
	____/____/____	☐ DFA/IFA ☐ rapid test ☐ PCR ☐ immunohistochem ☐ viral culture ☐ ____________ ☐ HI	☐ flu A ☐ flu B ☐ flu A/H1 ☐ flu A/H3 ☐ flu A unsubtypable ☐ flu A swine H1	☐ Positive ☐ Negative ☐ Indeterminate	
	____/____/____	☐ DFA/IFA ☐ rapid test ☐ PCR ☐ immunohistochem ☐ viral culture ☐ ____________ ☐ HI	☐ flu A ☐ flu B ☐ flu A/H1 ☐ flu A/H3 ☐ flu A unsubtypable ☐ flu A swine H1	☐ Positive ☐ Negative ☐ Indeterminate	
	____/____/____	☐ DFA/IFA ☐ rapid test ☐ PCR ☐ immunohistochem ☐ viral culture ☐ ____________ ☐ HI	☐ flu A ☐ flu B ☐ flu A/H1 ☐ flu A/H3 ☐ flu A unsubtypable ☐ flu A swine H1	☐ Positive ☐ Negative ☐ Indeterminate	
	____/____/____	☐ DFA/IFA ☐ rapid test ☐ PCR ☐ immunohistochem ☐ viral culture ☐ ____________ ☐ HI	☐ flu A ☐ flu B ☐ flu A/H1 ☐ flu A/H3 ☐ flu A unsubtypable ☐ flu A swine H1	☐ Positive ☐ Negative ☐ Indeterminate	
	____/____/____	☐ DFA/IFA ☐ rapid test ☐ PCR ☐ immunohistochem ☐ viral culture ☐ ____________ ☐ HI	☐ flu A ☐ flu B ☐ flu A/H1 ☐ flu A/H3 ☐ flu A unsubtypable ☐ flu A swine H1	☐ Positive ☐ Negative ☐ Indeterminate	
	____/____/____	☐ DFA/IFA ☐ rapid test ☐ PCR ☐ immunohistochem ☐ viral culture ☐ ____________ ☐ HI	☐ flu A ☐ flu B ☐ flu A/H1 ☐ flu A/H3 ☐ flu A unsubtypable ☐ flu A swine H1	☐ Positive ☐ Negative ☐ Indeterminate	
	____/____/____	☐ DFA/IFA ☐ rapid test ☐ PCR ☐ immunohistochem ☐ viral culture ☐ ____________ ☐ HI	☐ flu A ☐ flu B ☐ flu A/H1 ☐ flu A/H3 ☐ flu A unsubtypable ☐ flu A swine H1	☐ Positive ☐ Negative ☐ Indeterminate	
	____/____/____	☐ DFA/IFA ☐ rapid test ☐ PCR ☐ immunohistochem ☐ viral culture ☐ ____________ ☐ HI	☐ flu A ☐ flu B ☐ flu A/H1 ☐ flu A/H3 ☐ flu A unsubtypable ☐ flu A swine H1	☐ Positive ☐ Negative ☐ Indeterminate	
	____/____/____	☐ DFA/IFA ☐ rapid test ☐ PCR ☐ immunohistochem ☐ viral culture ☐ ____________ ☐ HI	☐ flu A ☐ flu B ☐ flu A/H1 ☐ flu A/H3 ☐ flu A unsubtypable ☐ flu A swine H1	☐ Positive ☐ Negative ☐ Indeterminate	

*Specimen type: nasopharyngeal swab, nasal aspirate/swab, oropharyngeal/throat swab, sputum, endotracheal aspirate, bronchoalveolar lavage (BAL), pleural fluid, blood, acute & convalescent serum (paired sera) , cerebrospinal fluid (CSF), pericardial fluid, peritoneal fluid, tissue (specify site), stool or urine
** Laboratory name, if the specimen was sent out

Assistance with diagnosis using BAL specimens and immunohistochemistry (IHC) is available at CDC. Please contact:
Sherif R. Zaki, MD, PhD
Tel: 404.639.3133 or E-mail: Sherif.Zaki@cdc.hhs.gov

Microbiology Results	STATE ID #: ________________	CDC ID#: __________________

Note all <u>significant</u> microbiology results, even rule-out results. If any bacterial, fungal or other non-influenza viruses were identified, please note the organism.

Specimen Type*	Collection Date mm/dd/yy	Test Type**	Interpretation	If Positive:		
				Organism 1	Organism 2	Organism 3
	____/____/____		☐ Positive ☐ Negative ☐ Indeterminate			
	____/____/____		☐ Positive ☐ Negative ☐ Indeterminate			
	____/____/____		☐ Positive ☐ Negative ☐ Indeterminate			
	____/____/____		☐ Positive ☐ Negative ☐ Indeterminate			
	____/____/____		☐ Positive ☐ Negative ☐ Indeterminate			
	____/____/____		☐ Positive ☐ Negative ☐ Indeterminate			
	____/____/____		☐ Positive ☐ Negative ☐ Indeterminate			
	____/____/____		☐ Positive ☐ Negative ☐ Indeterminate			
	____/____/____		☐ Positive ☐ Negative ☐ Indeterminate			
	____/____/____		☐ Positive ☐ Negative ☐ Indeterminate			
	____/____/____		☐ Positive ☐ Negative ☐ Indeterminate			
	____/____/____		☐ Positive ☐ Negative ☐ Indeterminate			
	____/____/____		☐ Positive ☐ Negative ☐ Indeterminate			

*Specimen type: nasopharyngeal swab, nasal aspirate/swab, oropharyngeal/throat swab, sputum, endotracheal aspirate, bronchoalveolar lavage (BAL), pleural fluid, blood, acute & convalescent serum (paired sera) , cerebrospinal fluid (CSF), pericardial fluid, peritoneal fluid, tissue (specify site), stool or urine
** Test type: culture, DFA/IFA, immunohistochemistry, PCR, rapid test, serology, etc.

Pathology and Histopathology	**STATE ID #:** _____	**CDC ID#:** _____		
Tissue Type and Findings	**Finding Present?**	**Date obtained** (mm/dd/yy)	**Type of exam**	**Comments**
Trachea and bronchi				
Submucosal congestion	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Submucosal mononuclear inflammation	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Necrosis of bronchial epithelium	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Other:	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Lung				
Mononuclear interstitial inflammation	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Hyaline membranes	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Intraalveolar hemorrhage	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Neutrophilic bronchopneumonia	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Other:	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Lymph nodes / lymphoid				
Hemophagocytosis	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Other:	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Heart				
Myocyte necrosis and inflammation	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Other:	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Skeletal muscle				
Rhabdomyolysis	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Other:	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Brain				
Inflammation, edema	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Other:	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Other tissue type*: _____				
	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
Other tissue type*: _____				
	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	
	☐ yes ☐ no ☐ NA	_____/_____/_____	☐ biopsy ☐ post mortem	

*adrenal, bone marrow, spinal cord, kidney, liver, , skin, spleen, etc

Was an autopsy performed? ☐ **yes** ☐ **no**

If YES, is there an autopsy report? ☐ **yes** ☐ **no**

Assistance with pathologic evaluation is available at CDC. Please contact:
Sherif R. Zaki, MD, PhD
Tel: 404.639.3133 or E-mail: Sherif.Zaki@cdc.hhs.gov

Severity of Illness	**STATE ID #:** _____	**CDC ID #:** _____

At any time during the current illness, did the patient require or have:

Admission to intensive care unit ☐ Yes ☐ No ☐ Unknown

→ If YES, Date admitted*: _____/_____/_____ Date discharged* _____/_____/_____

Supplemental oxygen ☐ Yes ☐ No ☐ Unknown

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

Ventilatory support Specify type: ☐ Mechanical ventilation ☐ ECMO ☐ Yes ☐ No ☐ Unknown

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

Vasopressor medications (e.g. dopamine, epinephrine) ☐ Yes ☐ No ☐ Unknown

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

Dialysis ☐ Yes ☐ No ☐ Unknown

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

Resuscitation, CPR ☐ Yes ☐ No ☐ Unknown

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

Acute respiratory distress syndrome (ARDS) ☐ Yes ☐ No ☐ Unknown

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

Disseminated intravascular coagulopathy (DIC) ☐ Yes ☐ No ☐ Unknown

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

Hemophagocytic syndrome ☐ Yes ☐ No ☐ Unknown

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

Sepsis ☐ Yes ☐ No ☐ Unknown

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

Shock Specify type: ☐ hypovolemic ☐ cardiogenic ☐ septic ☐ toxic ☐ Yes ☐ No ☐ Unknown

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

Myocardial dysfunction. Specify _____ ☐ Yes ☐ No ☐ Unknown

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

Myocardial infarct ☐ Yes ☐ No ☐ Unknown

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

Liver impairment (AST [SGOT] or ALT [SGPT] > 70 U/L or total bilirubin>2mg/dL) ☐ Yes ☐ No ☐ Unknown

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

Renal failure (serum creatinine ↑2X or GFR ↓ >50%normal or urine output <0.5ml/kg/h x 12hrs) ☐ Yes ☐ No ☐ Unknown

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

Encephalitis / encephalopathy ☐ Yes ☐ No ☐ Unknown

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

Other _____

→ If YES, Date started*: _____/_____/_____ Date stopped* _____/_____/_____

* Use format: mm/dd/yy

Outcome	**STATE ID #:** _____	**CDC ID #:** _____

1. Date of hospital discharge _____/_____/_____ mm / dd / yy

2. Current status

- ☐ Transferred to another hospital
- ☐ Discharge to home
- ☐ Currently hospitalized on ward
- ☐ Discharged to chronic care/rehabilitation facility
- ☐ Currently hospitalized in ICU
- ☐ Died Date: _____/ _____/ _____ mm / dd / yy

If the patient was pregnant at admission, at the time of hospital discharge provide information about the pregnancy outcome.

3. Pregnancy outcome:

- ☐ Still pregnant
- ☐ Uncomplicated labor and delivery
- ☐ Complicated labor and delivery Specify_____
- ☐ Fetal loss Date: _____/ _____/ _____ mm / dd / yy Specify_____

Neonatal outcome:

Birth: ____/____/____ mm / dd / yy

- ☐ Healthy newborn
- ☐ Ill newborn Specify_____
- ☐ Died Date: _____/ _____/ _____ mm / dd / yy

Notes: