

Influenza-Associated Pediatric Deaths Case Report Form

West Virginia Electronic Disease Surveillance System

Division of Surveillance and Disease Control

Infectious Disease Epidemiology Program

Phone: 304-558-5358 or 800-423-1271 in West Virginia

Fax: 304-558-8736

Disease Under Investigation

* indicates required fields

Investigation Status*

Closed Open Regional Review State Review Superseded Unassigned

Case Status*

Confirmed Not a Case Probable Suspect Unknown

Patient Information

* indicates required fields

Last Name*

First Name*

Middle Initial

Street Address

City

County

State

Zip

Is the patient's residence a:

Correctional Facility (Specify) _____ Long Term Care Facility (Specify) _____
 Shelter or Group Home (Specify) _____ None of the above

Home Phone

Ext.

Other Phone

Ext.

Report Date

###-###-####

###-###-####

mm/dd/yyyy

to

Parent / Guardian Information

Last Name

First Name

Middle Initial

Relationship to Patient

Check if address is same as above; otherwise complete guardian contact information below

Guardian Street Address

City

County

State

Zip

Home Phone

Ext.

Other Phone

Ext.

###-###-####

###-###-####

Patient Demographic Information

* indicates required fields

Sex

Male Female Transsexual Unknown Failure to report sex/missing sex Other (Specify) _____

Date of Birth*

Age

Age Units

mm/dd/yyyy

to

to

Days Weeks Months Years

Patient Demographic Information cont.

Ethnicity

Hispanic or Latino Not Hispanic or Latino Unknown Failure to report ethnicity/missing ethnicity

Race

(Check all that apply)

American Indian or Alaska Native Asian
 Black or African American Native Hawaiian or Other Pacific Islander _____
 White Unknown
 Failure to report race/missing race Some Other Race _____

Outcome and Clinical Information

Date of onset of symptoms

mm/dd/yyyy

to

Date of diagnosis

mm/dd/yyyy

to

Was the patient hospitalized for the disease?

Yes No Unknown

Name of Hospital

Date of Admission

mm/dd/yyyy

to

Patient outcome from this disease:

Died Survived Unknown

Date of Death

mm/dd/yyyy

to

Location of Death:

Home Emergency Dept (ER) Inpatient Ward ICU Other (specify) _____

Was the autopsy performed?

Yes No Unknown

Medical Care

Did the patient receive medical care for this illness?

Yes No Unknown

If YES, indicate level(s) of care received

(Check all that apply)

Outpatient clinic ER Inpatient Ward ICU Other (specify) _____

Did the patient require mechanical ventilation?

Yes No Unknown

Clinical Diagnoses and Complications

Check all complications that occurred during acute illness:

(Check all that apply)

NONE Pneumonia (Chest X-Ray confirmed) Acute Respiratory Disease Syndrome (ARDS) Croup
 Seizures Bronchiolitis Encephalopathy/Encephalitis Reye syndrome
 Shock Another Viral co-infection: Other (specify) _____

Check all medical conditions that existed before the start of the acute illness (check all that apply)

(Check all that apply)

NONE
 Moderate to severe developmental delay
 Hemaglobinopathy (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

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 (specify): _____

Laboratory Information

| | | | |
|------------------------|------------------------------|-------------|-----------------------------------|
| Laboratory Name | Phone ###-###-#### | Ext. | Fax Number ###-###-#### |
|------------------------|------------------------------|-------------|-----------------------------------|

Address

| | |
|--|-------------|
| State: <div style="background-color: #0056b3; height: 15px; width: 100%;"></div> | Zip: |
|--|-------------|

Influenza Testing (Check all that were used)

| Test Type | Result | Specimen Collection Date |
|---|--|--------------------------|
| <input type="checkbox"/> <i>Commercial rapid diagnostic test</i> | <input type="checkbox"/> <i>Influenza A</i> <input type="checkbox"/> <i>Influenza B</i> <input type="checkbox"/> <i>Negative</i> <input type="checkbox"/> <i>Influenza A/B (Not Distinguished)</i> | mm/dd/yyyy to |
| <input type="checkbox"/> <i>Viral Culture</i> | <input type="checkbox"/> <i>Influenza A (Subtyping Not Done)</i> <input type="checkbox"/> <i>Influenza B</i> <input type="checkbox"/> <i>Negative</i> <input type="checkbox"/> <i>Influenza A (Unable To Subtype)</i> <input type="checkbox"/> <i>Influenza A (H1)</i> <input type="checkbox"/> <i>Influenza A (H3)</i> | mm/dd/yyyy to |
| <input type="checkbox"/> <i>Direct fluorescent antibody (DFA)</i> | <input type="checkbox"/> <i>Influenza A</i> <input type="checkbox"/> <i>Influenza B</i> <input type="checkbox"/> <i>Negative</i> <input type="checkbox"/> <i>Influenza A/B</i> | mm/dd/yyyy to |
| <input type="checkbox"/> <i>Indirect fluorescent antibody (IFA)</i> | <input type="checkbox"/> <i>Influenza A</i> <input type="checkbox"/> <i>Influenza B</i> <input type="checkbox"/> <i>Negative</i> <input type="checkbox"/> <i>Influenza A/B</i> | mm/dd/yyyy to |
| <input type="checkbox"/> <i>Enzyme Immunoassay</i> | <input type="checkbox"/> <i>Influenza A (Subtyping Not Done)</i> <input type="checkbox"/> <i>Influenza B</i> <input type="checkbox"/> <i>Negative</i> <input type="checkbox"/> <i>Influenza A (Unable To Subtype)</i> <input type="checkbox"/> <i>Influenza A (H1)</i> <input type="checkbox"/> <i>Influenza A (H3)</i> | mm/dd/yyyy to |
| <input type="checkbox"/> <i>RT-PCR</i> | <input type="checkbox"/> <i>Influenza A (Subtyping Not Done)</i> <input type="checkbox"/> <i>Influenza B</i> <input type="checkbox"/> <i>Negative</i> <input type="checkbox"/> <i>Influenza A (Unable To Subtype)</i> <input type="checkbox"/> <i>Influenza A (H1)</i> <input type="checkbox"/> <i>Influenza A (H3)</i> | mm/dd/yyyy to |
| <input type="checkbox"/> <i>Immunohistochemistry (IHC)</i> | <input type="checkbox"/> <i>Influenza A</i> <input type="checkbox"/> <i>Influenza B</i> <input type="checkbox"/> <i>Negative</i> | mm/dd/yyyy to |

Laboratory Information cont.

Culture confirmation of INVASIVE bacterial pathogens

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 Unknown

| Name of the Bacteria Cultured | Result |
|---|------------------------|
| | Y=Yes N=No UNK=Unknown |
| Streptococcus Pneumoniae | |
| Haemophilus influenzae type b | |
| Haemophilus influenzae not-type b | |
| Neisseria meningitidis (serogroup, if known): | |
| Group A streptococcus (Streptococcus pyogenes) | |
| Staphylococcus aureus, methicillin sensitive | |
| Staphylococcus aureus, methicillin resistant (MRSA) | |
| Staphylococcus aureus, sensitivity not done | |
| Other invasive bacteria (specify below) | |

Other invasive bacteria

Reporting Source

| | | | |
|------------------------------|------------------|----------------------------|--|
| Last Name | | First Name | |
| Phone ###-###-#### | Ext. | Fax ###-###-#### | |
| Facility | | | |
| Address | | | |
| City | State | Zip | |
| E-mail | | | |

Provider with Further Patient Information

| | | | |
|------------------------------|------------------|----------------------------|--|
| Last Name | | First Name | |
| Phone ###-###-#### | Ext. | Fax ###-###-#### | |
| Address | | | |
| City | State | Zip | |

Public Health Investigation

| | | | | | |
|-----------------------------------|---|--|------------------------------|---|-------------|
| Name of Person Interviewed | | Relationship to Patient | | Date reported to Public Health mm/dd/yyyy to | |
| Investigator | Date Investigation Began mm/dd/yyyy to | Health Department | Phone ###-###-#### | | Ext. |
| Investigation ID | | Part of an Outbreak? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | Outbreak Name | |
| | | | | Lost to follow-up? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Check if epi-linked to another case and complete information below

| | | | | | |
|-------------------------------------|--|-------------------|--|---------------------------------------|--|
| Last Name of Epi-linked Case | | First Name | | DOB mm/dd/yyyy to | |
| County | | | | Onset Date mm/dd/yyyy to | |

Influenza Vaccine History

| | |
|---|--|
| Did the patient receive any influenza vaccine during the current season (before illness) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| If YES, please specify influenza vaccine received before illness onset: <input type="checkbox"/> Trivalent inactivated influenza vaccine (TIV) [infected] <input type="checkbox"/> Live-attenuated influenza vaccine (LAIV) [nasal spray] | |

If YES, how many doses did the patient receive and what was the timing of each dose? (Enter vaccination date 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 to | |
| <input type="checkbox"/> 2 doses | | <input type="checkbox"/> 2nd dose given <14 days prior to onset <input type="checkbox"/> 2nd dose given ≥14 days prior to onset | | Date of 1st dose: mm/dd/yyyy to | |
| Date of 2nd dose: mm/dd/yyyy to | | | | | |

| | |
|--|--|
| Did the patient receive any influenza vaccine in previous seasons? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
|--|--|

Public Health Action Taken

| |
|--|
| Describe public health action taken |
|--|