U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
AND PREVENTION
ATLANTA, GA 30333

Pediatric RSV-Associated Deaths – Case Report Form

Date Reported: ____/____/____

CDC Case ID: ____ ____ ____ ____ ____ ____ ____ ____

A. Reporter Information

Reporter Name: _____ (Last, First, M.I.) Email Address: _____

Title/Affiliation: _____ Phone No.1: ( ) _____ Phone No.2: ( ) _____

B. Demographics and General Information

1. County:

2. State:

3.Date of Birth: (MM/DD/YY) ____/____/____

4. Age: _____ ☐ Months (**or**) ☐ Days (if < 1 month)

5. Sex: ☐ Female ☐ Male

6. Race:
☐ White
☐ Black or African American
☐ Asian/Pacific Islander
☐ American Indian or Alaska Native
☐ Multiracial
☐ Unknown

7. Ethnicity:
☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unknown

8. Location of Death: ☐ Home ☐ ED ☐ Hospital ☐ Other
If other, specify: _____

8a. Hospital Name (if applicable): _____

8a. Admission Date: ____/____/____ (MM/DD/YY)

8b. Discharge Date: ____/____/____ (MM/DD/YY)

9. Was patient transferred from another hospital? ☐ Yes ☐ No ☐ Unknown

10a. Transfer Hospital Name: _____

10b. Transfer Hospital Admission Date: ____/____/____ (MM/DD/YY)

10c. Transfer Date: ____/____/____ (MM/DD/YY)

10. Was an autopsy performed? ☐ Yes ☐ No ☐ Unknown

10a. If yes, at which facility? _____

10b. COD findings: _____

C. RSV Testing Results

1. Test 1:
☐ Rapid Antigen Detection
☐ Molecular Assay (PCR)
☐ Viral Culture
☐ Serology
☐ Fluorescent Antibody
☐ Other, specify: _____

1a. Result:
☐ RSV A
☐ RSV B
☐ RSV A & B
☐ RSV A/B (Not Distinguished)

1b. Specimen collection date: ____/____/____ (MM/DD/YY)

1c. Testing facility: _____

2. Test 2:
☐ Rapid Antigen Detection
☐ Molecular Assay (PCR)
☐ Viral Culture
☐ Serology
☐ Fluorescent Antibody
☐ Other, specify: _____

2a. Result:
☐ RSV A
☐ RSV B
☐ RSV A & B
☐ RSV A/B (Not Distinguished)

2b. Specimen collection date: ____/____/____ (MM/DD/YY)

2c. Testing facility: _____

D. Intensive Care Unit and Interventions

1. Was diagnostic imaging performed (chest radiograph/CT/other)?
☐ Yes ☐ No ☐ Unknown

1a. If yes, describe any abnormal findings: _____

2. Was the patient admitted to an intensive care unit (ICU)? ☐ Yes ☐ No ☐ Unknown

2a. If yes, number of days in ICU: _____ ☐ Day(s) Unknown

3. Was patient intubated?
☐ Yes ☐ No ☐ Unknown

4. Did patient receive ECMO?
☐ Yes ☐ No ☐ Unknown

5. Did patient receive CPAP?
☐ Yes ☐ No ☐ Unknown

6. Did patient receive BiPAP?
☐ Yes ☐ No ☐ Unknown

E. Admission and Patient History

1. Acute signs/symptoms at admission (if applicable) or listed in relevant records regarding the illness and/or cause of death:

Cyanosis	☐ Yes	☐ No	☐ Unknown	Dehydration	☐ Yes	☐ No	☐ Unknown
Inability to eat, poor feeding	☐ Yes	☐ No	☐ Unknown	Ear ache/ear infection	☐ Yes	☐ No	☐ Unknown
Congested/runny nose	☐ Yes	☐ No	☐ Unknown	Myalgia/muscle aches	☐ Yes	☐ No	☐ Unknown
Decreased vocalization or stridor	☐ Yes	☐ No	☐ Unknown	Nausea/vomiting	☐ Yes	☐ No	☐ Unknown
Lethargy, less active or sleepy	☐ Yes	☐ No	☐ Unknown	Seizures	☐ Yes	☐ No	☐ Unknown
Cough	☐ Yes	☐ No	☐ Unknown	Shortness of breath/resp distress	☐ Yes	☐ No	☐ Unknown
Diarrhea	☐ Yes	☐ No	☐ Unknown	Sore throat	☐ Yes	☐ No	☐ Unknown
Wheezing	☐ Yes	☐ No	☐ Unknown	Hypothermia	☐ Yes	☐ No	☐ Unknown
Fever/chills (subjective)	☐ Yes	☐ No	☐ Unknown	Other, Specify:	☐ Yes	☐ No	☐ Unknown
Fever >=100.4F/38C	☐ Yes	☐ No	☐ Unknown	If yes, specify:			

2.Date of onset of acute respiratory symptoms:
____/____/____ (MM/DD/YY) ☐ Unknown

3.Additional comments. In particular, please note any further justification for RSV COD determination:
_____

4. Did patient have any of the following pre-existing medical conditions? Check all that apply. ☐ Past medical history is not available

4a. Asthma/Reactive Airway Disease ☐ Yes ☐ No ☐ Unknown

4b. Chronic Lung Disease ☐ Yes ☐ No ☐ Unknown
- ☐ Cystic fibrosis
- ☐ Chronic lung disease of prematurity/BPD
- ☐ Other, Specify: _____

4c. Abnormality of upper airway ☐ Yes ☐ No ☐ Unknown
If yes, specify: _____

4d. Chronic Metabolic Disease ☐ Yes ☐ No ☐ Unknown
- ☐ Diabetes Mellitus
- ☐ Other, Specify: _____

4e. Cardiovascular Disease ☐ Yes ☐ No ☐ Unknown
- ☐ Congenital heart disease
- ☐ Other, Specify: _____

4f. Neuromuscular disorder ☐ Yes ☐ No ☐ Unknown
- ☐ Mitochondrial disorder
- ☐ Other, Specify: _____

4g. Neurologic disorder ☐ Yes ☐ No ☐ Unknown
- ☐ Cerebral palsy
- ☐ Developmental delay (mod/sev)
- ☐ Down syndrome
- ☐ Plegias/Paralysis
- ☐ Seizure/Seizure disorder
- ☐ Other, Specify: _____

4h. Renal Disease ☐ Yes ☐ No ☐ Unknown
- ☐ Chronic kidney disease/chronic renal insufficiency
- ☐ Other, Specify: _____

4i. Immunocompromised Condition ☐ Yes ☐ No ☐ Unknown
- ☐ HIV Infection
- ☐ Cancer: current/in treatment or diagnosed in last 12 months
- ☐ Immunosuppressive therapy
- ☐ Steroid therapy (taken within 2 weeks of admission)
- ☐ Other, Specify: _____

4j. Blood disorders/Hemoglobinopathy ☐ Yes ☐ No ☐ Unknown
- ☐ Sickle cell disease
- ☐ Other, Specify: _____

4k. Liver disease ☐ Yes ☐ No ☐ Unknown
If yes, specify: _____

4l. Prematurity ☐ Yes ☐ No ☐ Unknown
If yes, specify gestational age at birth in weeks _____ ☐ Age Unknown
Based on ☐ birth record/certificate ☐ parent/guardian report

4m. Other ☐ Yes ☐ No ☐ Unknown
If yes, specify: _____

F. Bacterial Pathogens – *Sterile or respiratory site only*

1. Were any bacterial culture tests performed with a collection date within three weeks of death? ☐ Yes ☐ No ☐ Unknown

1a. If yes, was there a positive culture for a bacterial pathogen? ☐ Yes ☐ No ☐ Unknown

2. Results from culture

2a. If yes, specify Pathogen 1: _____

2b. Date of culture: ____/____/____ (MM/DD/YY)

2c. Site where pathogen identified:
- ☐ Blood
- ☐ Bronchoalveolar lavage (BAL)
- ☐ Pleural fluid
- ☐ Cerebrospinal fluid (CSF)
- ☐ Sputum
- ☐ Endotracheal aspirate
- ☐ Other, Specify: _____

2d. If Staphylococcus aureus, specify:
- ☐ Methicillin resistant (MRSA)
- ☐ Methicillin sensitive (MSSA)
- ☐ Sensitivity unknown

2e. If Haemophilus influenzae, specify if type B:
- ☐ Yes
- ☐ No
- ☐ Unknown

2f. If Neisseria meningitidis, specify serogroup:
- ☐ B ☐ C ☐ Y
- ☐ Other, Specify: _____
- ☐ Unknown

3. Results from culture

3a. If yes, specify Pathogen 2: _____

3b. Date of culture: ____/____/____ (MM/DD/YY)

3c. Site where pathogen identified:
- ☐ Blood
- ☐ Bronchoalveolar lavage (BAL)
- ☐ Pleural fluid
- ☐ Cerebrospinal fluid (CSF)
- ☐ Sputum
- ☐ Endotracheal aspirate
- ☐ Other, Specify: _____

3d. If Staphylococcus aureus, specify:
- ☐ Methicillin resistant (MRSA)
- ☐ Methicillin sensitive (MSSA)
- ☐ Sensitivity unknown

3e. If Haemophilus influenzae, specify if type B:
- ☐ Yes
- ☐ No
- ☐ Unknown

3f. If Neisseria meningitidis, specify serogroup:
- ☐ B ☐ C ☐ Y
- ☐ Other, Specify: _____
- ☐ Unknown

G. Viral Pathogens

1. Was patient tested for any of the following viral respiratory pathogens within 2 weeks of death? ☐ Yes ☐ No ☐ Unknown

1a. Influenza A	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____
1b. Influenza B	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____
1c. Adenovirus	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____
1d. Parainfluenza 1	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____
1e. Parainfluenza 2	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____
1f. Parainfluenza 3	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____
1g. Parainfluenza 4	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____
1h. Human metapneumovirus	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____
1i. Rhinovirus/Enterovirus	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____
1j. Coronavirus	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____
1k. Other respiratory virus,	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	**Date:** ____/____/____

Specify _____

H. COD Summary

1.

ICD-10 Cause of Death Codes
– For CDC use only

1a. _____
2b. _____
3c. _____
4d. _____
5e. _____
6f. _____
7g. _____
8h. _____
9i. _____

I. Prevention

1. Did patient receive palivizumab within 6 months prior death? ☐ Yes ☐ No ☐ Unknown

1a. If yes, specify dose date(s): (MM/DD/YY) ☐ Date Unknown

1. ____/____/____ 2. ____/____/____ 3. ____/____/____
4. ____/____/____ 5. ____/____/____

1b. If yes, source information
- ☐ Hospital record
- ☐ Outpatient record (EHR)
- ☐ Other