Severe Influenza Case History Form (ICU and Fatal Cases Age 0-64 Years)

Case definition: 1) lab-confirmed flu of any type; and 2) hospitalized in an ICU OR expired at any location (e.g. hospital, ER, home)

REQUIRED INFORMATION (if only the boxed area is completed, please attach relevant medical records if available (H&P, micro results, discharge sum, etc)

ICU case **Fatal case** Date of death: ____/____/____

Last name _____ **First name**_____ **DOB** ____/____/____

Street Address: _____ **City** _____ **Zip Code** _____

Race: White Black Native-American Asian/PI Other Unknown

Ethnicity: Hispanic Non-Hispanic **Sex:** Female Male **HCW**: Yes No Unk

Influenza Lab Confirmation: A -rapid test, culture or DFA positive only A (H3) Seasonal A H1N1

A -2009 H1N1 A -PCR positive, untypeable A -PCR positive, subtyping not done B

Hospital Name _____ **City** _____ **Date of admission:** ____/____/____

LHD _____ **LHD contact info:** _____

Date of onset of symptom(s) ____/____/____

Admit diagnosis _____

Symptoms that occurred prior to admission

Fever ≥37.8 Cough Sore throat

Nausea/vomiting Myalgia Diarrhea

Shortness of breath Altered mental status

Seizures O_2 sat __% on RA

Other: _____

Significant past medical history

Cardiac disease Yes No

Unk Chronic pulmonary disorder Yes No

Unk Immunosuppression (e.g., cancer) Yes No

Unk Metabolic disorder (e.g. DM, renal) Yes No

Unk Neuromuscular disorder (e.g. CP) Yes No

Unk Hemoglobinopathy (e.g. SCD) Yes No

Unk Genetic disorder (e.g. Downs) Yes No

Unk Immunosuppressive meds (e.g, steroids) Yes No

Unk Gastrointestinal disease (e.g, GE reflux) Yes No

Unk Prematurity Yes No Unk *If yes, # weeks gestation:*_

Pregnant Yes No Unk *If yes, EDC:* __/__/__

Postpartum Yes No Unk *If yes, delivery:* __/__/__

Weight: _____ kg lbs Height: _____ BMI: ____

Other conditions (e.g., hypertension) Yes No Unk

If YES for <u>any</u> of the above, please specify: _____

Vaccination Status

Vaccinated for flu >14 days prior? Yes No Unk

If yes, number of doses: One Two

If yes, type of vaccine: Inactivated FluMist

Diagnostic/Laboratory Studies

Chest X-ray Pos Neg Not done

Findings: _____

Other abnormal results (LP, MRI/CT, LFTs, etc.)

Method of influenza diagnosis

Rapid test IFA/DFA PCR Culture

Other _____

2° bacterial infection: Yes No Unk

If yes, community-acquired hospital-acquired

Specify pathogen:_____

Specimen source: _____

Date collected: ____/____/____

Other micro results: _____

Clinical course

Antiviral treatment: Yes No Unk

Type: _____ Dose: _____

Dates of treatment: ____/____/____ to ____/____/____

Intubated Yes No Unk

Date of discharge: ____/____/____

Discharged to: Home Rehab

Complications

Pneumonia ARDS Sepsis Renal failure

Enceph-alitis/alopathy Pulmonary embolus

Other, specify: _____

CDPH Influenza fax: **916-440-5984**

TO REPORT A CASE, PLEASE CONTACT NAPA COUNTY HEALTH DEPARTMENT (CD UNIT @ 707-253-4231) AND FAX THIS FORM TO: (707) 299-4479. Please forward any available medical records (e.g. H&P, micro reports, discharge summary, autopsy report). Please contact your local health department or CDPH to report these cases ASAP so that we can assist with collection and shipment of specimens for further characterization.