



Influenza-Associated Pediatric Deaths Case Report Form

Form approved
OMB No. 0920-0007

STATE USE ONLY – DO NOT SEND INFORMATION IN THIS SECTION TO CDC

Last Name: _____ First Name: _____ County: _____
Address: _____ City: _____ State, Zip: _____

Patient Demographics

1. State:	2. County:	3. State ID:	4. CDC ID:
5. Age: _____ <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Years	6. Date of birth: _____/_____/_____ MM DD YYYY	7. Sex: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	8. Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
9. Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Unknown			

Death Information

10. Date of illness onset: _____/_____/_____ MM DD YYYY	11. Date of death: _____/_____/_____ MM DD YYYY	12 a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 12 b. Were pathology specimens sent to CDC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
13 a. Did cardiac/respiratory arrest occur outside the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
13 b. Location of death: <input type="checkbox"/> Outside Hospital <input type="checkbox"/> Emergency Dept (ER) <input type="checkbox"/> Inpatient ward <input type="checkbox"/> ICU <input type="checkbox"/> Other (specify): _____		

Influenza Testing (check all that were used)

Test Type	Result	Specimen Collection Date
<input type="checkbox"/> Commercial rapid diagnostic test	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A/B (Not Distinguished)	____/____/____
<input type="checkbox"/> Viral culture	<input type="checkbox"/> Influenza A (Subtyping Not Done) <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A (Unable To Subtype) <input type="checkbox"/> Influenza A (H1) <input type="checkbox"/> Influenza A (H3)	____/____/____
<input type="checkbox"/> Direct fluorescent antibody (DFA)	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A/B	____/____/____
<input type="checkbox"/> Indirect fluorescent antibody (IFA)	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A/B	____/____/____
<input type="checkbox"/> Enzyme immunoassay (EIA)	<input type="checkbox"/> Influenza A (Subtyping Not Done) <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A (Unable To Subtype) <input type="checkbox"/> Influenza A (H1) <input type="checkbox"/> Influenza A (H3)	____/____/____
<input type="checkbox"/> RT-PCR	<input type="checkbox"/> Influenza A (Subtyping Not Done) <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A (Unable To Subtype) <input type="checkbox"/> Influenza A (H1) <input type="checkbox"/> Influenza A (H3)	____/____/____
<input type="checkbox"/> Immunohistochemistry (IHC)	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative	____/____/____



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Culture confirmation of INVASIVE bacterial pathogens

14 a. Was a specimen collected for bacterial culture from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid)? Yes No Unknown

14 b. If yes, please indicate the site from which the specimen was obtained.

<input type="checkbox"/> Blood	Date ___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Unknown
<input type="checkbox"/> Pleural fluid	Date ___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Unknown
<input type="checkbox"/> CSF	Date ___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other _____	Date ___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Unknown
<input type="checkbox"/> Unknown	Date ___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Unknown

14 c. If positive, please check the organism cultured.

<input type="checkbox"/> <i>Streptococcus pneumoniae</i>	<input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin sensitive	<input type="checkbox"/> <i>Neisseria meningitidis</i> (serogroup, if known): _____
<input type="checkbox"/> <i>Haemophilus influenzae</i> type b	<input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin resistant (MRSA)	<input type="checkbox"/> Group A streptococcus
<input type="checkbox"/> <i>Haemophilus influenzae</i> not-type b	<input type="checkbox"/> <i>Staphylococcus aureus</i> , sensitivity not done	<input type="checkbox"/> Other bacteria: _____

Culture confirmation of bacterial pathogens from NON-STERILE SITES

14 d. Were other respiratory specimens collected for bacterial culture (e.g., sputum, ET tube aspirate)? Yes No Unknown

14 e. If yes, please indicate the site from which the specimen was obtained.

<input type="checkbox"/> Sputum	Date ___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Unknown
<input type="checkbox"/> ET tube	Date ___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other _____	Date ___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Unknown
<input type="checkbox"/> Unknown	Date ___/___/___	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Unknown

14 f. If positive, please check the organism cultured.

<input type="checkbox"/> <i>Streptococcus pneumoniae</i>	<input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin sensitive	<input type="checkbox"/> <i>Neisseria meningitidis</i> (serogroup, if known): _____
<input type="checkbox"/> <i>Haemophilus influenzae</i> type b	<input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin resistant (MRSA)	<input type="checkbox"/> Group A streptococcus
<input type="checkbox"/> <i>Haemophilus influenzae</i> not-type b	<input type="checkbox"/> <i>Staphylococcus aureus</i> , sensitivity not done	<input type="checkbox"/> Other bacteria: _____

Medical Care

15. Did the patient receive medical care for this illness before admission to the hospital or death if outside the hospital? Yes* No Unknown

16. If YES*, indicate level(s) of care received (check all that apply): Outpatient clinic ER Inpatient ward ICU

17. Did the patient require mechanical ventilation? Yes No Unknown



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Clinical Diagnoses and Complications

18 a. Did complications occur during the acute illness: Yes No Unknown

18 b. If yes, check all complications that occurred during the acute illness:

Pneumonia (Chest X-Ray confirmed) Acute Respiratory Disease Syndrome (ARDS) Croup Seizures

Bronchiolitis Encephalopathy/encephalitis Reye syndrome Shock

Another viral co-infection: _____ Other: _____

19 a. Did the child have any medical conditions that existed before the start of the acute illness: Yes No Unknown

19 b. If yes, check all medical conditions that existed before the start of the acute illness:

Moderate to severe developmental delay Hemoglobinopathy (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) _____ Skin or soft tissue infection

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

20 a. Was the patient receiving any of the following therapies in the 7 days prior to illness onset or after illness onset? (check all that apply)

Aspirin or aspirin-containing products NSAID or NSAID-containing products

20 b. Was the patient receiving any of the following therapies prior to illness onset? (check all that apply)

Antibiotic therapy Chemotherapy or radiation therapy Steroids by mouth or injection other immunosuppressive therapy: _____

Antiviral therapy specify _____

Influenza vaccine history

21. Did the patient receive any influenza vaccine during the current season (before illness) Yes* No Unknown

22. If YES*, please specify influenza vaccine received before illness onset: Trivalent inactivated influenza vaccine (TIV) [injected] Live-attenuated influenza vaccine (LAIV) [nasal spray] Unknown

23. If YES*, how many doses did the patient receive and what was the timing of each dose? (Enter vaccination dates 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	
<input type="checkbox"/> 2 doses	<input type="checkbox"/> 2 nd dose given <14 days prior to onset <input type="checkbox"/> 2 nd dose given ≥14 days prior to onset	Date of 1 st dose: ____/____/____ MM DD YYYY	Date of 2 nd dose: ____/____/____ MM DD YYYY

24. Did the patient receive any influenza vaccine in previous seasons? Yes No Unknown

Submitted By: _____ Date: ____/____/____
 Phone No.: (____) _____ MM DD YYYY
 E-mail Address: _____

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-0007).