



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	____/____/____



Influenza-Associated Pediatric Deaths Case Report Form

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)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
14 b. If yes, please indicate the site from which the specimen was obtained.		
<input type="checkbox"/> Blood	Date <u> </u> / <u> </u> / <u> </u>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
<input type="checkbox"/> Pleural fluid	Date <u> </u> / <u> </u> / <u> </u>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
<input type="checkbox"/> CSF	Date <u> </u> / <u> </u> / <u> </u>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
<input type="checkbox"/> Other _____	Date <u> </u> / <u> </u> / <u> </u>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
<input type="checkbox"/> Unknown	Date <u> </u> / <u> </u> / <u> </u>	<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)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
14 e. If yes, please indicate the site from which the specimen was obtained.		
<input type="checkbox"/> Sputum	Date <u> </u> / <u> </u> / <u> </u>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
<input type="checkbox"/> ET tube	Date <u> </u> / <u> </u> / <u> </u>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
<input type="checkbox"/> Other _____	Date <u> </u> / <u> </u> / <u> </u>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
<input type="checkbox"/> Unknown	Date <u> </u> / <u> </u> / <u> </u>	<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? <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown		
16. If YES* , indicate level(s) of care received (check all that apply): <input type="checkbox"/> Outpatient clinic <input type="checkbox"/> ER <input type="checkbox"/> Inpatient ward <input type="checkbox"/> ICU		
17. Did the patient require mechanical ventilation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		



Influenza-Associated Pediatric Deaths Case Report Form

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

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)

- 1 dose ONLY <14 days prior to illness onset Date dose given: ____/____/____
 ≥14 days prior to illness onset MM DD YYYY
- 2 doses 2nd dose given <14 days prior to onset Date of 1st dose: ____/____/____ Date of 2nd dose: ____/____/____
 2nd dose given ≥14 days prior to onset MM DD YYYY 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).