Influenza-Associated Pediatric Mortality Case Report Form

Form Approved
OMB No. 0920-0004

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: _____ O Days O Months O Years	6. Date of birth: _____/ _____/ _____ MM DD YYYY	7a. Is sex known? ☐ Yes ☐ No 7b. Sex: O Male O Female	

8a. Is ethnicity known? ☐ Yes ☐ No

8b. Ethnicity: O Hispanic or Latino O Not Hispanic or Latino

9a. Is race known? ☐ Yes ☐ No

9b. Race: ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native

Death Information

10. Date of illness onset: _____/ _____/ _____ MM DD YYYY	11. Date of death: _____/ _____/ _____ MM DD YYYY	12. Was an autopsy performed? O Yes O No O Unknown

13 a. Did cardiac/respiratory arrest occur outside the hospital? O Yes O No O Unknown

13 b. Location of death: O Outside the Hospital (e.g. home or in transit to hospital) O Emergency Dept (ED) O Inpatient ward O ICU
O Other (specify): _____

13 c. If the death occurred in the hospital, what was the date of admission? _____/ _____/ _____ MM DD YYYY

CDC Laboratory Specimens

14 a. Were pathology specimens sent to CDC's Infectious Diseases Pathology Branch? O Yes O No O Unknown
Please provide the lab ID No. if known_____

14 b. Were influenza isolates or original clinical material sent to CDC's Influenza Division? O Yes O No O Unknown
Please provide the lab ID No. if known_____

Public reporting burden of this collection of information is estimated to average 30 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0004).

Influenza Testing (check all that were used)

Test Type	Result	Specimen Collection Date
15. ☐ Commercial rapid diagnostic test	O Influenza A O Influenza B O Negative O Influenza A/B (Not Distinguished) O 2009 Influenza A (H1N1) O Influenza virus co-infection (specify)_____	_____/ _____/ _____
☐ Viral culture	O Influenza A (Subtyping Not Done) O 2009 Influenza A (H1N1) O Influenza A (H3) O Influenza A (H3N2v) O Influenza A (Unable To Subtype) O Influenza B (Lineage Not Determined) O Influenza B/Victoria lineage O Influenza B/Yamagata lineage O Influenza virus co-infection (specify)_____ O Negative	_____/ _____/ _____
☐ Fluorescent antibody (IFA or DFA)	O Influenza A (Subtyping Not Done) O Influenza B O Negative O Influenza A (Unable To Subtype) O Influenza A (H3) O 2009 Influenza A (H1N1) O Influenza virus co-infection (specify)_____	_____/ _____/ _____
☐ Enzyme immunoassay (EIA)	O Influenza A (Subtyping Not Done) O Influenza B O Negative O Influenza A (Unable To Subtype) O Influenza A (H3) O 2009 Influenza A (H1N1) O Influenza virus co-infection (specify)_____	_____/ _____/ _____
☐ RT-PCR	O Influenza A (Subtyping Not Done) O 2009 Influenza A (H1N1) O Influenza A (H3) O Influenza A (H1) O Influenza A (H3N2v) O Influenza A (Unable To Subtype) O Influenza B (Lineage Not Determined) O Influenza B/Victoria lineage O Influenza B/Yamagata lineage O Influenza virus co-infection (specify)_____ O Negative	_____/ _____/ _____
☐ Immunohistochemistry (IHC)	O Influenza A O Influenza B O Negative O Influenza virus co-infection (specify)_____	_____/ _____/ _____

Culture confirmation of bacterial pathogens from STERILE (Invasive) SITES

16 a. Was a specimen collected for bacterial culture from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid? **Specimens collected greater than 24 hours after death are not sterile.** O Yes O No O Unknown

16 b. If yes, please indicate the site from which the specimen was obtained and the result. *If more than one specimen type is positive and more than one organism is identified please indicate the organism cultured from each specimen type in the comments section.*

Specimen Type	Collection Date	Result
☐ Blood	Date __/__/__	O Positive O Negative O Unknown
☐ Pleural fluid	Date __/__/__	O Positive O Negative O Unknown
☐ CSF	Date __/__/__	O Positive O Negative O Unknown
☐ Lung Tissue	Date __/__/__	O Positive O Negative O Unknown
☐ Other _____	Date __/__/__	O Positive O Negative O Unknown
☐ Unknown		

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

☐ *Streptococcus pneumoniae*

☐ Group A *Streptococcus*

☐ Other bacteria: _____
(If reporting another viral co-infection please do so in section 18 Clinical Diagnosis and Complications)

☐ *Staphylococcus aureus,* methicillin **sensitive (MSSA)**

☐ *Staphylococcus aureus,* methicillin **resistant (MRSA)**

☐ *Staphylococcus aureus,* **sensitivity not done**

☐ *Haemophilus influenzae* not-type b

☐ *Haemophilus influenzae* type b

☐ *Pseudomonas aeruginosa*

Culture confirmation of bacterial pathogens from NON-STERILE SITES

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

16 e. If yes, please indicate the site from which the specimen was obtained and the result. *If more than one specimen type is positive and more than one organism is identified please indicate the organism cultured from each specimen type in the comments section.*

Specimen Type	Collection Date	Result
☐ Sputum	Date __/__/__	O Positive O Negative O Unknown
☐ ET tube	Date __/__/__	O Positive O Negative O Unknown
☐ Other _____	Date __/__/__	O Positive O Negative O Unknown
☐ Unknown		

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

☐ *Streptococcus pneumoniae*	☐ *Staphylococcus aureus,* methicillin **sensitive (MSSA)**	☐ *Haemophilus influenzae* not-type b
☐ Group A *Streptococcus*	☐ *Staphylococcus aureus,* methicillin **resistant (MRSA)**	☐ *Haemophilus influenzae* type b
☐ Other bacteria:	☐ *Staphylococcus aureus,* **sensitivity not done**	☐ *Pseudomonas aeruginosa*

_____

(If reporting another viral co-infection please do so in section 18 Clinical Diagnosis and Complications)

Pathology confirmation of bacterial pathogens

16 g. Was a specimen (e.g., fixed lung tissue) collected from an autopsy for testing of bacterial pathogens by a local or state pathologist? *(If pathology results are available from CDC it is not necessary to input those results here, however please make sure to complete section 14 "CDC Laboratory Specimens")* O Yes O No O Unknown

If yes please indicate the results of these tests in the comments section at the end of the form.

Medical Care

17. Was the patient placed on mechanical ventilation? O Yes O No O Unknown

Clinical Diagnoses and Complications

18 a. Did complications occur during the acute illness? O Yes O No O 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

☐ Sepsis ☐ Hemorrhagic pneumonia/pneumonitis ☐ Cardiomyopathy/myocarditis

☐ Another viral co-infection: _____ ☐ Other: _____

19 a. Did the child have any medical conditions that existed before the start of the acute illness? O Yes O No O 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/congenital heart disease (specify) _____ ☐ Renal disease (specify) _____ ☐ Skin or soft tissue infection (SSTI)

☐ Chromosomal Abnormality/Genetic Syndrome (specify) _____ ☐ Mitochondrial Disorder (specify) _____

☐ Chronic pulmonary disease (specify) _____ ☐ Immunosuppressive condition (specify) _____

☐ Cancer (diagnosis and/or treatment began in previous 12 months) (specify)_____ ☐ Endocrine disorder (specify) _____ ☐ Obesity ☐ Cerebral Palsy ☐ Premature at birth (specify gestational age) ____ weeks

☐ Neuromuscular disorder (e.g. muscular dystrophy) (specify) _____ ☐ Other Neurological disorder (specify) _____

☐ Pregnant (specify gestational age) _____ weeks ☐ Other (specify) _____

Medication and Therapy History

20 a. Was the patient receiving any of the following therapies ***prior*** to illness onset?
(if yes, check all that apply)

☐ Yes ☐ No ☐ Unknown

☐Antiviral Prophylaxis ☐ Chronic aspirin therapy ☐ Chemotherapy or radiation therapy ☐ Steroids by mouth or injection

☐ Other immunosuppressive therapy:_____

20 b. Did the patient receive any of the following ***after*** illness onset? **(if yes, check all that apply)**

☐ Yes ☐ No ☐ Unknown

☐ Antibiotic therapy specify_____ ☐ Antiviral therapy specify_____

Influenza Vaccine History

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

22. **If YES*,** please specify the influenza vaccine received before illness onset:
- ☐ Inactivated influenza vaccine (IIV3) *[injected]*
- ☐ Quadrivalent inactivated influenza vaccine (IIV4) *[injected]*
- ☐ Live-attenuated influenza vaccine (LAIV4) *[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)

O 1 dose **ONLY**
- ☐ <14 days prior to illness onset
- ☐ ≥14 days prior to illness onset

Date dose given:_____/ _____/ _____ MM DD YYYY

O 2 doses
- ☐ 2nd dose given <14 days prior to onset
- ☐ 2nd dose given ≥14 days prior to onset

Date of 1st dose: _____/ _____/_____ MM DD YYYY

Date of 2nd dose: _____/ _____/ _____ MM DD YYYY

23b. IF the patient received two doses of influenza vaccine during the current season, please specify the SECOND influenza vaccine received before illness onset:
- ☐ Inactivated influenza vaccine (IIV3) *[injected]*
- ☐ Quadrivalent inactivated influenza vaccine (IIV4) *[injected]*
- ☐ Live-attenuated influenza vaccine (LAIV4) *[nasal spray]*
- ☐ Unknown

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

24 a. **If YES**, and patient was **≤8 years of age** at the time of death, did they receive 2 doses of vaccine during a previous season? O Yes O No O Unknown

Submitted By: _____Date: _____/ _____/ _____ MM DD YYYY

Phone No.: (_____) _____-_____

E-mail Address: _____

Case Investigation Closed: ☐ Yes ☐ No