INFLUENZA DEATH CASE HISTORY FORM

Fax this form to (562) 570-4374

PATIENT INFORMATION

Last name	*First name*	*Date of birth*

Street address	*City*	*Zip code*	*Local health jurisdiction of residence*

Gender	*Ethnicity*	*Race*
☐ Female ☐ Male	☐ Hispanic ☐ Non-Hispanic ☐ Unknown	☐ White ☐ Black ☐ Native American ☐ Asian/Pacific Islander ☐ Other ☐ Unknown

ONSET, VACCINATION HISTORY, HOSPITALIZATION AND DEATH INFORMATION

Date of onset of symptoms	*Received this season's influenza vaccine?* ☐ Yes ☐ No ☐ Unknown	*Date received: Dose 1*	*Dose 2*

If hospitalized, hospital name and location	*Date of hospital admission*	*Date of hospital discharge*

If died, date of death	*If died, location of death (e.g. home, ED-name of hospital ED, etc.)*	*If died, autopsy performed?* ☐ Yes ☐ No ☐ Unknown

INFLUENZA LABORATORY TESTING INFORMATION (Please attach a copy of the test result, if available)

Date of specimen collection	*Specimen type (e.g. nasopharyngeal swabs, endotracheal aspirate, bronchoalveolar lavage)*

Influenza type and/or subtype — *Where was testing performed?*

Influenza A: ☐(H3) ☐(2009H1N1) ☐(A Unknown – PCR) ☐(A Unknown – rapid test, culture or DFA) ☐ (A – PCR unsubtypable (i.e. novel))

Influenza B: ☐(Yamagata) ☐(Victoria) ☐(B Unknown) ☐ (B Unknown -- rapid test, culture or DFA)

REPORTING AGENCY INFORMATION

Reporting local health jurisdiction	*Name of reporter*	*Telephone number of reporter*

CLINICAL COURSE

Received antiviral treatment? ☐ Yes ☐ No ☐ Unknown	*Type of antiviral* ☐ Oseltamivir ☐ Zanamivir ☐ Other *Specify other*: _____

Date antiviral treatment started	*Date antiviral treatment ended*	*Intubated?* ☐ Yes ☐ No ☐ Unknown

Complications

☐ Pneumonia ☐ ARDS ☐ Sepsis ☐ Acute renal failure ☐ Encephalitis/encephalopathy ☐ Required vasopressor ☐ Required hemodialysis

☐ Pulmonary embolus ☐ Secondary bacterial infection *If yes, specify organism*: _____

☐ Other *Specify other*: _____

SIGNIFICANT PAST MEDICAL HISTORY

Did the patient have underlying medical conditions? ☐ Yes ☐ No ☐ Unknown

☐ Cardiac disease ☐ Chronic pulmonary disorder ☐ Immunosuppression (e.g. cancer) ☐ Immunosuppressive medications (e.g. chemotherapy, steroids)

☐ Metabolic disorder (e.g. diabetes mellitus, renal) ☐ Neurological disorder (e.g. cerebral palsy) ☐ Hemoglobinopathy (e.g. sickle cell disease)

☐ Genetic disorder (e.g. Downs) ☐ Obesity *If obese*, BMI (if known): _____ Height: _____ Weight: _____

☐ Pregnant *If pregnant*, estimated delivery date: _____

☐ Postpartum *If postpartum*, delivery date: _____ ☐ Other conditions (e.g. hypertension, hyperlipidemia)

If yes for any of the above, please specify:

NOTES SECTION (Please attach relevant medical records if available)