



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="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	6. Date of birth: _____/_____/_____ MM DD YYYY	7. Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unkown	8. Ethnicity: <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> 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. Was an autopsy performed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
13 a. Did cardiac/respiratory arrest occur outside the hospital? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
13 b. Location of death: <input type="radio"/> Outside the Hospital (e.g. home or in transit to hospital) <input type="radio"/> Emergency Dept (ED) <input type="radio"/> Inpatient ward <input type="radio"/> ICU <input type="radio"/> 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? Please provide the lab ID No. if known _____	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
14 b. Were influenza isolates or original clinical material sent to CDC's Influenza Division? Please provide the lab ID No. if known _____	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
14 c. Were <i>Staph aureus</i> isolates sent to CDC's Division of Healthcare Quality Promotion? Please provide the lab ID No. if known _____	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown



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Influenza Testing (check all that were used)		
Test Type	Result	Specimen Collection Date
15. <input type="checkbox"/> Commercial rapid diagnostic test	<input type="radio"/> Influenza A <input type="radio"/> Influenza B <input type="radio"/> Negative <input type="radio"/> Influenza A/B (Not Distinguished) <input type="radio"/> 2009 Influenza A (H1N1) <input type="radio"/> Influenza virus co-infection (specify) _____	____/____/____
<input type="checkbox"/> Viral culture	<input type="radio"/> Influenza A (Subtyping Not Done) <input type="radio"/> Influenza B <input type="radio"/> Negative <input type="radio"/> Influenza A (Unable To Subtype) <input type="radio"/> Influenza A (H1) <input type="radio"/> Influenza A (H3) <input type="radio"/> 2009 Influenza A (H1N1) <input type="radio"/> Influenza virus co-infection (specify) _____	____/____/____
<input type="checkbox"/> Fluorescent antibody (IFA or DFA)	<input type="radio"/> Influenza A (Subtyping Not Done) <input type="radio"/> Influenza B <input type="radio"/> Negative <input type="radio"/> Influenza A (Unable To Subtype) <input type="radio"/> Influenza A (H1) <input type="radio"/> Influenza A (H3) <input type="radio"/> 2009 Influenza A (H1N1) <input type="radio"/> Influenza virus co-infection (specify) _____	____/____/____
<input type="checkbox"/> Enzyme immunoassay (EIA)	<input type="radio"/> Influenza A (Subtyping Not Done) <input type="radio"/> Influenza B <input type="radio"/> Negative <input type="radio"/> Influenza A (Unable To Subtype) <input type="radio"/> Influenza A (H1) <input type="radio"/> Influenza A (H3) <input type="radio"/> 2009 Influenza A (H1N1) <input type="radio"/> Influenza virus co-infection (specify) _____	____/____/____
<input type="checkbox"/> RT-PCR	<input type="radio"/> Influenza A (Subtyping Not Done) <input type="radio"/> Influenza B <input type="radio"/> Negative <input type="radio"/> Influenza A (Unable To Subtype) <input type="radio"/> Influenza A (H1) <input type="radio"/> Influenza A (H3) <input type="radio"/> 2009 Influenza A (H1N1) <input type="radio"/> Influenza virus co-infection (specify) _____	____/____/____
<input type="checkbox"/> Immunohistochemistry (IHC)	<input type="radio"/> Influenza A <input type="radio"/> Influenza B <input type="radio"/> Negative <input type="radio"/> 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) O Yes O No O Unknown		
16 b. If yes, please indicate the site from which the specimen was obtained and the result. <i>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.</i>		
<u>Specimen Type</u>	<u>Collection Date</u>	<u>Result</u>
<input type="checkbox"/> Blood	Date ___/___/___	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown
<input type="checkbox"/> Pleural fluid	Date ___/___/___	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown
<input type="checkbox"/> CSF	Date ___/___/___	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown
<input type="checkbox"/> Other _____	Date ___/___/___	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown
<input type="checkbox"/> Unknown		
16 c. If positive, please check the organism cultured.		
<input type="checkbox"/> <i>Streptococcus pneumoniae</i>	<input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin sensitive (MSSA)	<input type="checkbox"/> <i>Haemophilus influenzae</i> not-type b
<input type="checkbox"/> Group A streptococcus	<input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin resistant (MRSA)	<input type="checkbox"/> <i>Haemophilus influenzae</i> type b
<input type="checkbox"/> Other bacteria: _____ <i>(If reporting another viral co-infection please do so in section 19 Clinical Diagnosis and Complications)</i>	<input type="checkbox"/> <i>Staphylococcus aureus</i> , sensitivity not done	<input type="checkbox"/> <i>Pseudomonas aeruginosa</i>



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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
<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		

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

- | | | |
|--|---|---|
| <input type="checkbox"/> <i>Streptococcus pneumoniae</i> | <input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin sensitive (MSSA) | <input type="checkbox"/> <i>Haemophilus influenzae</i> not-type b |
| <input type="checkbox"/> Group A streptococcus | <input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin resistant (MRSA) | <input type="checkbox"/> <i>Haemophilus influenzae</i> type b |
| <input type="checkbox"/> Other bacteria: | <input type="checkbox"/> <i>Staphylococcus aureus</i> , sensitivity not done | <input type="checkbox"/> <i>Pseudomonas aeruginosa</i> |

(If reporting another viral co-infection please do so in section 19 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



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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
- 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? 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/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 Prematurity (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 _____



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Influenza Vaccine History			
21. Did the patient receive any seasonal influenza vaccine during the current season (before illness) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
22. If YES* , please specify the seasonal influenza vaccine received before illness onset:			
		<input type="checkbox"/> Trivalent inactivated influenza vaccine (TIV) [<i>injected</i>] <input type="checkbox"/> Live-attenuated influenza vaccine (LAIV) [<i>nasal spray</i>] <input type="checkbox"/> Unknown	
23. If YES for seasonal vaccine* , how many doses did the patient receive and what was the timing of each dose? (Enter vaccination dates if available)			
O 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	
O 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 seasonal influenza vaccine in previous seasons? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
24 a. If YES to question 24 , and patient was between 6 months and ≤ 8 years of age at the time of death, was the 2009-2010 influenza season the first time the patient received seasonal influenza vaccine? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
24b. If YES to question 24a , did the patient receive 2 doses of seasonal influenza vaccine during the 2009-2010 influenza season? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
25. If the patient was between 6 months and ≤ 8 years of age at the time of death, did they receive at least one dose of 2009 influenza A (H1N1) vaccine during the previous season? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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).