



# Influenza Fatality Case Report Form (Confirmed Fatal Cases Only)



COUNTY:   LAC   VCMR ID: \_\_\_\_\_

**Fax completed form to Acute Communicable Disease Control as (213) 482-4856**

Patient Name-Last		First	Middle Initial	Date of Birth	Age	Sex
Address- Number, Street, Apt #			City	State	ZIP Code	
Telephone Number		Occupation		Medical Record No.		
Race (check one) <input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Other: _____				Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino		

**PRESENT ILLNESS**

Onset Date	Admit Date	Date of Death	Nosocomial Infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital/Facility Name
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Symptoms on presentation to hospital (check all that apply):  
 Diarrhea    Nausea/vomiting   Admission Temp \_\_\_\_\_ C / F  
 Altered mental status    Headache    Seizures  
 Cough    Sore throat    Body aches    Fatigue  
 Shortness of breath  
 Other Specify: \_\_\_\_\_

Complications that occurred during acute illness(check all that apply):  
 ARDS    Encephalitis/meningitis    Sepsis  
 Bacterial pneumonia    Viral pneumonia  
 Organ failure   Specify organs: \_\_\_\_\_  
 Other Specify: \_\_\_\_\_

Weight: \_\_\_\_\_ kg or \_\_\_\_\_ lbs   Height: \_\_\_\_\_ cm or \_\_\_\_\_ in  
 Body mass index: \_\_\_\_\_  
 Antivirals received?    Yes    No    Unknown  
 If yes, specify type: \_\_\_\_\_  
 If yes, start date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Prior to death, was the patient...**  
 Seen as an outpatient for this respiratory illness?    Yes    No    Unknown  
 If yes, specify date(s): \_\_\_\_\_  
 Given antivirals?    Yes    No    Unknown  
 If yes, specify type and dates: \_\_\_\_\_  
 Given antibiotics?    Yes    No    Unknown  
 If yes, specify type: \_\_\_\_\_

Significant past medical history:	Yes	No	Unk
Non-smoker.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify # of weeks: _____			
≤6 wks Postpartum.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify # of weeks: _____			
Other conditions.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**DIAGNOSTIC TESTS**

**Influenza/Microbiology testing [attach copy of microbiology reports]:**

	Collection Date	Testing Facility	Specimen Source	Result							
				A	B	A/B	Pan. H1	Ssnl. H1	H3	Unsubtypable	Negative
Rapid Influenza Test				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IFA/DFA Test				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Viral Culture				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza PCR				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other viral/bacterial pathogens detected? :    Yes    No    Unknown      If yes, please record below:

Test Type	Collection Date	Testing Facility	Specimen Source	Pathogen(s) Detected

**CONTACT INFORMATION**

Submitter Name (print)	Title	Telephone Number	Date Completed	Abstractor Initials
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