COUNTY OF LOS ANGELES PUBLIC HEALTH
Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212
Los Angeles, CA 90012
213-240-7941 (phone)
213-482-4856 (facsimile)
publichealth.lacounty.gov/acd/

Influenza Fatality Case Report Form
(Confirmed Fatal Cases Only)

Fax completed form to Acute Communicable Disease Control at (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.	VCMR ID

Race (check one)
☐ African-American/Black ☐ Asian/Pacific Islander ☐ Native American ☐ White ☐ Other: _____

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

PRESENT ILLNESS

Onset Date	Admit Date	Date of Death	Hospital/Facility Name	Nosocomial Infection? ☐ Yes ☐ No

Symptoms
☐ Sore throat ☐ Cough ☐ Rhinorrhea
☐ Fever: Temp_____ ☐ Diarrhea ☐ Nausea/Vomiting
☐ Altered mental status ☐ Headache
☐ Shortness of breath ☐ Fatigue
☐ Other Specify. _____

Complications
☐ Pneumonia ☐ ARDS ☐ Sepsis ☐ Encephalitis/meningitis
☐ Organ failure If yes, specify organ:_____
☐ Other Specify. _____

Significant Past Medical History
☐ Hypertension ☐ Cardiovascular Disease ☐ Lung Disease
☐ Immunosupression (cancer or medications) ☐ Neurological disorder
☐ Genetic disorder ☐ Diabetes ☐ Asthma
☐ Overweight or Obese: BMI_____ Height_____ Weight_____
☐ Smoker or history of smoking
☐ History of drug or alcohol abuse
☐ Pregnant If yes, specify # of weeks: _____
☐ Postpartum If yes, delivery date: _____
☐ Other conditions: _____

Received Flu vaccine? ☐ Yes ☐ No ☐ Unknown If yes, date of vaccination: _____

Received antiviral treatment? ☐ Yes ☐ No ☐ Unknown If yes, type of antiviral: ☐ Oseltamivir ☐ Zanamivir ☐ Other Specify. _____
Date antiviral started: _____/_____/_____ **and** ended: _____/_____/_____

DIAGNOSTIC TESTS

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

Test	Collection Date	Testing Facility	Specimen Source	Flu Type or Subtype (i.e. A, B, A/B, Pandemic H1, Seasonal H1, H3, Unsubtypable)
Rapid Influenza Test				
IFA/DFA Test				
Viral Culture				
Influenza PCR				

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	Email Address