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/

# Fatal Respiratory Syncytial Virus (RSV) Report Form

COUNTY: _____ VCMR ID: _____

**Patients must be: 1) under 5 years,**
**2) have confirmed syncytial virus by laboratory testing, AND**
**3) expired at any location (e.g. hospital, ER, home, etc).**

| Patient Name-Last | First | Middle Initial | Date of Birth | Age | Sex |
|---|---|---|---|---|---|
| | | | | | |

| Address- Number, Street, Apt # | City | State | ZIP Code |
|---|---|---|---|
| | | | |

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

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

## PRESENT ILLNESS

| Onset Date | Hospitalized? ☐ Yes ☐ No | Admit date | Discharge Date | Medical Record No. | Was case considered a healthcare-associated Infection (HAI)? ☐Yes ☐No ☐Unk |
|---|---|---|---|---|---|
| | | | | | |

Hospital Name

**Symptoms that occurred during current illness** (check all that apply):

☐ Fever (≥ 38° C) ☐ Seizures ☐ Apnea
☐ Altered consciousness ☐ Nausea/vomiting ☐Hypoxia
☐ Lower respiratory (cough,shortness of breath, wheezing,bronchospasm)
☐ Other Specify. _____

**Complications that occurred** (check all that apply)**:**

☐ Pneumonia ☐ ARDS ☐ Secondary bacterial pneumonia
☐ Bronchiolitis ☐ Encephalitis/encephalopathy
☐ Myocarditis ☐ Sepsis ☐ Multi-organ Failure
☐ Other, specify _____

Received Prophylaxis (i.e. Palividumab)? ☐ Yes ☐ No ☐ Unk
If Yes, Type:_____

Received Antivirals? ☐ Yes ☐ No ☐ Unk
If Yes, Type: _____

Recent travel? ☐ Yes* ☐ No ☐ Unk
If Yes*, Where?_____

Recent ill contacts? ☐ Yes ☐ No ☐ Unk
If hospitalized, intubated? ☐ Yes ☐ No ☐ Unk

Vaginal or C-section birth? ☐ V ☐ C ☐ Unk

Chest X-ray? ☐ Yes ☐ No ☐ Unk
If Yes, Result: ☐ Normal ☐ Abnormal Describe:_____

**Significant past medical history:**

☐ No Past History ☐ Cardiac issue ☐Immunosuppression (HIV)
☐ Lung Disease ☐ Metabolic disorder (diabetes mellitus, renal)
☐ Neuromuscular disorder ☐ Febrile seizures
☐ Seizure disorder ☐ Cancer chemo ☐ Developmental delay
☐ Hemoglobinopathy (SCD) ☐ Radiation therapy
☐ Long-term aspirin therapy ☐ Steroids by mouth/injection
☐ Immunosuppressive meds ☐ Premature? Yes, # weeks_____
Other conditions _____

**Vaccines:**

Flu vaccine current season: ☐ Yes ☐ Yes - self report ☐ No ☐ Unknown
Route: ☐ Injected ☐ Nasal spray Date of vaccination: ____/____/___
Receive pneumococcal vaccine *ever*? ☐ Y ☐ Y – Self report ☐ No ☐Unk
If Yes, # of doses _____

**Treatment:**

☐Antiobitics ☐Terbutaline
☐Steroids (PO/IV) ☐Epinephrine (IM/SQ/NEB, not IV)
☐Steroids (inhaled) ☐Magnesium Sulfate
☐Vasopressor Medication ☐Ipratropium
☐Albuterol or levalbuterol ☐Other Asthma Medications

**Birth History:**

Check here if not documented ☐
Was patient born ≥1 month early ☐Yes ☐ No ☐Unk
If yes, how many weeks early _____ **OR** gestational age at birth (weeks) _____

Routine Home Medications: List all chronic medications taken by patient at home including prescribed, over the counter, herbal:

_____

Recent Medications: List all medications taken by patient related to this illness:

_____

**Presenting Physical Exam:** Triage/Admit Vital Signs

Abnormal lung sounds (wheeze/rhonchi/rales/decreased breath sounds) ☐Yes ☐ No ☐ Unk
Signs of respiratory distress (nasal flare, retractions, tachypnea) ☐Yes ☐ No ☐Unk
Supplemental Oxygen required ☐Yes ☐ No ☐ Unk
Recorded temperature _____ [ PO AX PR ND ] Check here if not recorded ☐
Heart rate _____ Check here if not recorded ☐
Respiratory rate _____ Check here if not recorded ☐
Oxygen saturation _____ [ Room Air Supp $O_2$ ND ] Check here if not recorded ☐

Patient name (last, first) _____ Date of Birth _____ VCMR ID: _____

## PRESENT ILLNESS (CONTINUED)

**Chart Review:** Clinical Course

Max temperature w/in 7 days_____ Date _____ [ PO AX PR ND ] Check here if not recorded ☐

At any time during the current illness, did the patient require or have:

Admission to Intensive Care Unit ☐ Yes ☐ No If yes, admit date _____/_____/_____ **AND** Discharge date _____/_____/_____

Supplemental O2 ☐ Yes ☐ No If yes, length of time _____days_____ hours

| | | | |
|---|---|---|---|
| BiPAP/CPAP | ☐No | ☐Yes → | If yes, length of time _____ days _____hours |
| Mechanical ventilation | ☐No | ☐Yes → | If yes, length of time _____ days _____hours |
| Nitric Oxide | ☐No | ☐Yes → | If yes, length of time _____ days _____hours |
| ECMO | ☐No | ☐Yes → | If yes, length of time _____ days _____hours |
| Resuscitation/CPR | ☐No | ☐Yes → | If yes, number of times_____ |

**Disposition:**

Location of death? ☐ Died at home ☐Died in ED ☐Died in Hospital ☐Other (*specify*) _____

Autopsy performed? ☐ Yes ☐ No ☐ Unk If yes, date _____ MM/DD/YYYY

Relevant findings _____

## DIAGNOSTIC TESTS

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

| Test Type | Collection Date | Testing Facility | Specimen Source | Subtype if known |
|---|---|---|---|---|
| Rapid RSV Test | | | | |
| RVP rt-PCR | | | | |
| Cell Culture | | | | |
| Rapid Flu or PCR (choose one) | | | | |

**Other viral/bacterial pathogens detected? : ☐ Yes ☐ No ☐ Unknown If Yes, please record:**

## CONTACT INFORMATION

| Submitter Name (print) | Title | Telephone Number | Email Address |
|---|---|---|---|
| | | | |

To report a case, fax this form to: Los Angeles County Department of Public Health
Acute Communicable Disease Control Phone 213-240-7941 Fax 213-482-4856