

Pediatric Influenza-Associated Death Supplemental Form



COUNTY: _____ VCMR ID: _____

| | | | | | |
|---|-------|----------------|--|-----|-----|
| Patient Name-Last | First | Middle Initial | Date of birth | Age | Sex |
| 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 | | |
| If Asian/Pacific Islander, please check one: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____ | | | | | |

DEATH INFORMATION

| | | |
|--|---|---|
| Date of illness onset: ____/____/____ MM DD YYYY | Date of death: ____/____/____ MM DD YYYY | Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| | | Were pathology specimens sent to CDC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Did cardiac/respiratory arrest occur outside the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| Location of death: <input type="checkbox"/> Outside Hospital <input type="checkbox"/> Emergency Dept (ER) <input type="checkbox"/> Inpatient ward <input type="checkbox"/> ICU <input type="checkbox"/> Other (specify): _____ | | |

Medication and Therapy History

| | |
|--|---|
| Did the patient receive any of the following therapies in the 7 days prior to illness onset or after illness onset? (check all that apply) <input type="checkbox"/> Aspirin or aspirin-containing products <input type="checkbox"/> NSAID or NSAID-containing products | Did the patient receive any of the following therapies prior to illness onset? (check all that apply) <input type="checkbox"/> Antibiotic therapy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Steroids by mouth or injection <input type="checkbox"/> Antiviral therapy or radiation therapy Specify _____ therapy injection therapy: _____ |
|--|---|

DIAGNOSTIC TESTING

Influenza Testing (check all that were used)

| Test Type | Result | Specimen Collection Date |
|--|--|--------------------------|
| <input type="checkbox"/> Commercial rapid diagnostic test | <input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A/B (Not Distinguished) | ____/____/____ |
| <input type="checkbox"/> Viral culture | <input type="checkbox"/> Influenza A (Subtyping Not Done) <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A (Unable To Subtype) <input type="checkbox"/> Influenza A (H1) <input type="checkbox"/> Influenza A (H3) | ____/____/____ |
| <input type="checkbox"/> Direct fluorescent antibody (DFA) | <input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A/B | ____/____/____ |
| <input type="checkbox"/> Indirect fluorescent antibody (IFA) | <input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A/B | ____/____/____ |
| <input type="checkbox"/> Enzyme immunoassay (EIA) | <input type="checkbox"/> Influenza A (Subtyping Not Done) <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A (Unable To Subtype) <input type="checkbox"/> Influenza A (H1) <input type="checkbox"/> Influenza A (H3) | ____/____/____ |
| <input type="checkbox"/> RT-PCR | <input type="checkbox"/> Influenza A (Subtyping Not Done) <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A (Unable To Subtype) <input type="checkbox"/> Influenza A (H1) <input type="checkbox"/> Influenza A (H3) | ____/____/____ |
| <input type="checkbox"/> Immunohistochemistry (IHC) | <input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative | ____/____/____ |

Culture confirmation of INVASIVE bacterial pathogens

Was a specimen collected for bacterial culture from a normally sterile site (e.g., blood, CSF, tissue, or pleural fluid)? Yes* No Unknown

If yes*, please indicate the site from which the specimen was obtained:

- | | | |
|--|---------------------|--|
| <input type="checkbox"/> Blood | Date ____/____/____ | <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Pleural fluid | Date ____/____/____ | <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown |
| <input type="checkbox"/> CSF | 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 | | |

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

Culture confirmation of INVASIVE bacterial pathogens (Continued)

What was the result of the bacterial culture? Positive* Negative Unknown

If positive*, please check the organism cultured:

- | | | |
|---|---|---|
| <input type="checkbox"/> <i>Streptococcus pneumoniae</i> | <input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin sensitive | <input type="checkbox"/> <i>Neisseria meningitidis</i> (serogroup, if known):____ |
| <input type="checkbox"/> <i>Haemophilus influenzae</i> type b | <input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin resistant (MRSA) | <input type="checkbox"/> Group A streptococcus |
| <input type="checkbox"/> <i>Haemophilus influenzae</i> not-type b | <input type="checkbox"/> <i>Staphylococcus aureus</i> , sensitivity not done | <input type="checkbox"/> Other invasive bacteria: _____ |

Culture confirmation of bacterial pathogens from NON-STERILE SITES

Were other respiratory specimens collected for bacterial culture (e.g., sputum, ET tube aspirate)? Yes* No Unknown

If yes*, please indicate the site from which the specimen was obtained:

- | | | |
|--------------------------------------|---------------|--|
| <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 | | |

What was the result of the bacterial culture? Positive* Negative Unknown

If positive*, please check the organism cultured:

- | | | |
|---|---|---|
| <input type="checkbox"/> <i>Streptococcus pneumoniae</i> | <input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin sensitive | <input type="checkbox"/> <i>Neisseria meningitidis</i> (serogroup, if known):____ |
| <input type="checkbox"/> <i>Haemophilus influenzae</i> type b | <input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin resistant (MRSA) | <input type="checkbox"/> Group A streptococcus |
| <input type="checkbox"/> <i>Haemophilus influenzae</i> not-type b | <input type="checkbox"/> <i>Staphylococcus aureus</i> , sensitivity not done | <input type="checkbox"/> Other bacteria: _____ |

REMARKS

CONTACT INFORMATION

| Physician/ Infection Preventionist Name | Facility | Pager number | Fax number | E-mail address |
|---|----------|--------------|------------|----------------|
| | | () | () | |