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/

Novel Influenza A (H1N1) Case Report Form
(Hospitalized and Fatal Cases)

COUNTY: __LAC________________ CDPH ID: _CA____________ VCMR ID: ________________

Patients must have: **1) a clinical syndrome consistent with influenza or its complications; 2) either probable or confirmed novel influenza A (H1N1) by laboratory testing; 3) been either hospitalized OR expired at any location (e.g. hospital, ER, home, etc).**

Case Status: ☐ Probable ☐ Confirmed

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 ☐ Asian/Pacific Islander ☐ Native American ☐ White ☐ Other:_____

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

PRESENT ILLNESS

Onset date	Hospital admit date	Discharge date	Intubated? ☐ Yes ☐ No ☐ Unk	Hospital Name	Medical Record No.

Level of medical care (check all that apply):
☐ Outpatient Clinic ☐ Emergency Room ☐ Inpatient Ward
☐ Intensive Care Unit ☐ None

Symptoms that occurred during current illness (check all that apply):
☐ Fever ≥ 38° C ☐ Cough ☐ Sore throat ☐ Nausea/vomiting
☐ Diarrhea ☐ Muscle aches ☐ Altered mental status
☐ Shortness of breath ☐ Apnea ☐ Seizures
☐ Other Specify. ___________________________________

Complications that occurred during acute illness(check all that apply):
☐ Pneumonia/ARDS ☐ Bronchiolitis
☐ 2° bacterial pneumonia ☐ Encephalitis/encephalopathy
☐ Myocarditis ☐ Sepsis/Multi-Organ Failure
☐ Other Specify. ___________________________________

Antivirals received (if any) and dates: ________________________
____
____
____

Outcome? ☐ Died ☐ Recovered ☐ Unk
If died, date of death :_____/ _____/ _____

Significant past medical history:	Yes	No	Unk
Cardiac disease……………………………………………..	☐	☐	☐
Chronic pulmonary disorder (e.g. asthma, cystic fibrosis) …..	☐	☐	☐
Immunosuppression (e.g. HIV, malignancy) …………………..	☐	☐	☐
Metabolic disorder (e.g. diabetes mellitus, renal) ……………..	☐	☐	☐
Neuromuscular disorder ………………………(e.g. seizure disorder, developmental delay/MR, hypoxic encephalopathy, etc)	☐	☐	☐
Hemoglobinopathy (e.g. SCD) ………………………………	☐	☐	☐
Long-term aspirin therapy…………………………………	☐	☐	☐
Genetic disorder (e.g. Downs) ………………………………	☐	☐	☐
Immunosuppressive medications (e.g. steroids) …………..	☐	☐	☐
Prematurity ………………………………………………..	☐	☐	☐
If yes, # of weeks gestation: ______			
Gastrointestinal disease (e.g. GE reflux) …………………..	☐	☐	☐
Pregnancy………………………………………………..	☐	☐	☐
If yes, specify # of weeks: _______			
Obesity …………………………………………………	☐	☐	☐
If yes, weight (lbs.): _____ height (inches): _____			
Other conditions ……………………………………………	☐	☐	☐

If Yes for any of the above, please specify. ____________________________
____

VACCINE HISTORY

Was patient vaccinated for influenza this season (at least 14 days prior to onset of symptoms) ☐ Yes* ☐ No ☐ Unk

If yes *, please specify influenza vaccine received before illness onset:
☐ Trivalent inactivated influenza vaccine (TIV) *[injected]*
☐ Live-attenuated influenza vaccine (LAIV) *[nasal spray]*

If yes *, how many doses did the patient receive? ☐ 1 dose ☐ 2 doses

Did the patient receive any influenza vaccine in previous seasons? ☐ Yes ☐ No ☐ Unk

DIAGNOSTIC TESTS

Laboratory studies:

CBC: Hct _______ Plt _______ WBC _______

Chest X-ray: ☐ Positive ☐ Negative ☐ Not done Findings: ______________________________

Chest CT: ☐ Positive ☐ Negative ☐ Not done Findings: ______________________________

Lumbar puncture: ☐ Positive ☐ Negative ☐ Not done Findings: ______________________________

Other pertinent labs (LFTs, MRI/CT, etc.), if available. ______________________________

CONFIDENTIAL – This material is subject to the Official Information Privilege Act

Patient name (last, first) ______________________ Date of Birth ____________ VCMR ID: __________

DIAGNOSTIC TESTS (Continued)

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

Rapid Influenza Test: ☐ Yes* ☐ No ☐ Unk If yes*, ☐ Positive ☐ Negative

Influenza diagnosed by other methods (check all that apply): ☐ IFA/DFA ☐ PCR ☐ Viral Culture ☐ Other, specify: ______________

Influenza PCR result: ☐ Unsubtypeable ☐ Novel flu A (H1)

Rapid RSV test result: ☐ Positive ☐ Negative ☐ Not done

Other viral/bacterial pathogens detected? : ☐ Yes* ☐ No ☐ Unk

If yes*, specify source: ☐ Sputum ☐ ET asp ☐ BAL ☐ Pleural Fluid ☐ Blood ☐ Other, specify: ______________

If yes*, specify pathogen: ______________________________

Other micro results: ______________________________

EPIDEMIOLOGIC RISK FACTORS

Recent travel? ☐ Yes* ☐ No ☐ Unk If yes*, where? ______________________________

Recent ill contacts? ☐ Yes* ☐ No ☐ Unk If yes*, who? ______________________________

REMARKS (Please include any available medical records – e.g. H & P, laboratory reports, discharge summary, autopsy report)

CONTACT INFORMATION

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

CONFIDENTIAL – This material is subject to the Official Information Privilege Act