COUNTY OF LOS ANGELES
Public Health

INFLUENZA-ASSOCIATED DEATH CASE REPORT FORM

PATIENT DEMOGRAPHICS

Last name | First name | Middle initial | Date of birth | Incident ID

Street address ☐ Homeless | Apt #

City | State: CA | Zip code

Skilled nursing/Long-term care/Assisted living resident? ☐ Yes ☐ No ☐ Unknown

If yes, facility name

Occupation

Gender identity
☐ Female ☐ Male ☐ Refused/Unknown
☐ Transgender Female/Trans Woman
☐ Transgender Male/Trans Man
☐ Gender Non-Binary/Non-Conforming
☐ Other: _____

Sex at birth
☐ Female ☐ Male ☐ Non-Binary or X
☐ Refused/Unknown
☐ Other: _____

Race/ethnicity (all that apply)
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American
☐ Hispanic/Latinx/Spanish origin ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Refused/Unknown ☐ Other: _____

Sexual orientation
☐ Bisexual ☐ Gay or Lesbian
☐ Straight or Heterosexual
☐ Not sure ☐ Refused/Unknown
☐ Other: _____

ILLNESS HISTORY

Symptom onset date | Hospital admission date | Date of death | Location of death (e.g. home, hospital)

If hospitalized, hospital name | Medical record number | **Autopsy performed?** ☐ Yes ☐ No ☐ Unknown

Hospital diagnoses
☐ Pneumonia ☐ Sepsis/Septic shock
☐ ARDS ☐ Encephalitis/encephalopathy
☐ Respiratory failure ☐ AKI/Renal failure
☐ Heart failure
☐ Secondary infection, organism: _____
☐ Other: _____

Patient required:
☐ Intubation ☐ Vasopressors
☐ Hemodialysis due to illness?

Vaccinated this season?
☐ Yes ☐ No ☐ Unknown
Date vaccinated: _____

Received influenza antivirals? ☐ Yes ☐ No ☐ Unknown
☐ Oseltamivir ☐ Zanamivir ☐ Peramivir ☐ Baloxavir ☐ Other

Antiviral start date: _____ | Antiviral end date: _____

MEDICAL HISTORY

☐ Cardiovascular disease
☐ Chronic Lung Disease (E.g. Asthma, COPD)
☐ Diabetes Mellitus
☐ Renal disease (E.g. CKD, ERSD)
☐ Liver disease
☐ Immunosuppression (e.g. cancer)
☐ Overweight or Obese: BMI_____ Height_____ ☐in/ ☐cm Weight_____ ☐lbs ☐kg
☐ Other conditions:

☐ Hemoglobinopathy (E.g. sickle cell disease)
☐ Genetic disorder (e.g. Downs)
☐ Pregnant If yes, specify # of weeks: _____
☐ Postpartum If yes, delivery date: _____
☐ Neurodevelopmental/ Neurologic disorder (e.g. cerebral palsy)
☐ Immunosuppressive medication (e.g. chemotherapy, steroids)

Laboratory (include laboratory slip with report)

Test type	Date collected	Source	Result
☐PCR/NAAT ☐Rapid antigen ☐IFA/DFA ☐Viral Culture			**Influenza A:** ☐ (H1)pdm09 ☐ (H3) ☐Unk **Influenza B:** ☐ Yamagata ☐ Victoria ☐Unk
☐PCR/NAAT ☐Rapid antigen ☐IFA/DFA ☐Viral Culture			**Influenza A:** ☐ (H1)pdm09 ☐ (H3) ☐Unk **Influenza B:** ☐ Yamagata ☐ Victoria ☐Unk

Testing laboratory:

COVID test in prior 90 days? ☐ Yes, Positive (Date: _____) ☐ Yes, Negative ☐ Not done ☐ Unknown

Investigation

Name of reporter | Phone | Email | Date | Medical records reviewed? ☐ Yes ☐ No