



# Pediatric Severe Influenza Case Report Form

COUNTY: \_\_\_\_\_ VCMR ID: \_\_\_\_\_

**Patients must be: 1) 0-17 years; 2) have confirmed influenza by laboratory testing and 3) have been hospitalized in the PICU OR 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) <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		

## PRESENT ILLNESS

Onset date	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Admit date	Medical record no.	Hospital Name																																																																				
Level of medical care (check all that apply): <input type="checkbox"/> Outpatient clinic <input type="checkbox"/> Emergency Room <input type="checkbox"/> Inpatient ward <input type="checkbox"/> Pediatric Intensive Care Unit <input type="checkbox"/> None			Significant past medical history:																																																																					
Symptoms that occurred during current illness (check all that apply): <input type="checkbox"/> Fever ( $\geq 38^\circ\text{C}$ ) <input type="checkbox"/> Seizures <input type="checkbox"/> Apnea <input type="checkbox"/> Altered consciousness <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Lower respiratory (cough, shortness of breath, wheezing, bronchospasm) <input type="checkbox"/> Other Specify: _____			<table border="1"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> <th>Unk</th> </tr> </thead> <tbody> <tr><td>Cardiac disease.....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Chronic pulmonary disorder (e.g. asthma, cystic fibrosis)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Immunosuppression (e.g. HIV, malignancy) .....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Metabolic disorder (e.g. diabetes mellitus, renal)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Neuromuscular disorder.....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>History of febrile seizures.....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Seizure disorder.....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Developmental delay.....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Hemoglobinopathy (e.g. SCD).....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Long-term aspirin therapy.....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Steroids by mouth/injection.....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Cancer chemotherapy.....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Radiation therapy.....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Other immunosuppressive medications .....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Pregnancy....If Yes, specify # of weeks _____</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Other conditions.....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>			Yes	No	Unk	Cardiac disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pulmonary disorder (e.g. asthma, cystic fibrosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppression (e.g. HIV, malignancy) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metabolic disorder (e.g. diabetes mellitus, renal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuromuscular disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of febrile seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental delay.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemoglobinopathy (e.g. SCD).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Long-term aspirin therapy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Steroids by mouth/injection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other immunosuppressive medications .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy....If Yes, specify # of weeks _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other conditions.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Complications that occurred during acute illness(check all that apply): <input type="checkbox"/> Pneumonia/ARDS <input type="checkbox"/> Secondary bacterial pneumonia <input type="checkbox"/> Bronchiolitis <input type="checkbox"/> Encephalitis/encephalopathy <input type="checkbox"/> Myocarditis <input type="checkbox"/> Sepsis/Multi-organ Failure <input type="checkbox"/> Other, specify _____			If Yes for any of the above, please specify: _____																																																																					
Antibiotics/antivirals received (if any) and dates: _____																																																																								
Recent travel? <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unk If yes*, where? _____																																																																								
Recent ill contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk																																																																								
If hospitalized, intubated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk																																																																								
Outcome? <input type="checkbox"/> Died* <input type="checkbox"/> Recovered <input type="checkbox"/> Unk																																																																								

**\*If Died, complete Pediatric Death Supplemental Form**

## VACCINE HISTORY

Did the patient receive any influenza vaccine during the current season (before illness)  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]  
 Unk

If yes \*, how many doses did the patient receive and what was the timing of each dose? (Enter vaccination dates if available)

<input type="checkbox"/> 1 dose ONLY	<input type="checkbox"/> <14 days prior to illness onset <input type="checkbox"/> $\geq 14$ days prior to illness onset	Date dose given: ____/____/____ MM DD YYYY	
<input type="checkbox"/> 2 doses	<input type="checkbox"/> 2 <sup>nd</sup> dose given <14 days prior to onset <input type="checkbox"/> 2 <sup>nd</sup> dose given $\geq 14$ days prior to onset	Date of 1 <sup>st</sup> dose: ____/____/____ MM DD YYYY	Date of 2 <sup>nd</sup> dose: ____/____/____ MM DD YYYY

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

Did the patient receive pneumococcal vaccine?  Yes\*  No  Unk

If yes \*, how many doses did the patient receive? \_\_\_\_\_

**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. \_\_\_\_\_

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

Method of influenza detection (check all that apply):  
 Rapid Influenza Test (EIA)  IFA/DFI  PCR  Viral Culture  Other, specify: \_\_\_\_\_  
 Influenza type, if known:  Influenza A  Influenza B  Unk  
 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: \_\_\_\_\_  
 Blood culture:  Positive\*  Negative  Not done  
 If Positive\*, pathogen: \_\_\_\_\_  
 Respiratory culture:  Positive\*  Negative  Not done  
 If Positive\*, specify specimen (n-p swab/wash, o-p swab, ET aspirate, sputum, BAL, pleural fluid) and pathogen: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Other micro results: \_\_\_\_\_

**REMARKS**

**CONTACT INFORMATION**

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