

Severe Pediatric Influenza Case History Form

Patients must have 1) age 0-17 years; 2) a clinical syndrome consistent with influenza or its complications; 3) influenza confirmed by laboratory testing; and 3) been either hospitalized in the PICU OR expired at any location (e.g. hospital, ER, home, etc).

Patient Information:

Last name _____ First name _____ DOB ____/____/____ Sex: Female Male
 Street Address: _____ City _____ Zip Code _____
 Race: White Black Native American Asian/PI Other Unknown Ethnicity: Hispanic Non-Hispanic

Date onset of symptom(s): ____/____/____
 Level of medical care (check all that apply):
 Outpatient clinic ER Inpatient Ward
 PICU None Medical Record # _____
 Recent travel? Yes No If yes, where: _____
 Recent ill contacts: Yes No If yes, who: _____
 If hospitalized, date of admission: ____/____/____

Symptoms that occurred during the current illness:
 Fever $\geq 38^{\circ}$ Seizures Apnea
 Altered consciousness Nausea/vomiting
 Lower respiratory symptoms (cough, shortness of breath, wheezing, bronchospasm)
 Other; specify _____

Complications that occurred during the acute illness:
 Pneumonia/ARDS Bronchiolitis
 2^o bacterial pneumonia Encephalitis/encephalopathy
 Myocarditis Sepsis/Multi-organ Failure
 Other, specify _____

Significant Past Medical History (check all that apply)

Cardiac disease Yes No Unk
 Chronic pulmonary disorder Yes No Unk
 Immunosuppressed (e.g. HIV, cancer): Yes No Unk
 Metabolic disorder (e.g. DM, renal) Yes No Unk
 Neuromuscular disorder (e.g., seizure disorder, developmental delay/MR, hypoxic encephalopathy, etc) Yes No Unk
 Hemoglobinopathy (e.g. SCD): Yes No Unk
 Long-term aspirin therapy: Yes No Unk
 Genetic disorder (e.g. Downs,) Yes No Unk
 Immunosuppressive meds (e.g. steroids): Yes No Unk
 Prematurity: Yes No Unk If yes, #weeks gestation: _____
 Gastrointestinal disease (e.g. GE reflux) Yes No Unk
 Pregnant: Yes No Unk If yes, #weeks: _____
 Other conditions: Yes No Unk

If YES for **any** of the above, please specify:

Vaccination Status:

Was patient vaccinated for influenza this season (at least 14 days prior to onset of symptoms)? Yes No Unk
 If yes, how many doses: One Two
 If yes, type of vaccine: Inactivated FluMist
 Vaccinated for influenza in prior seasons? Yes No Unk
 Ever received pneumococcal vaccine? Yes No Unk
 If yes, how many doses? _____

Diagnostic/Laboratory Studies:

CBC: Hct _____ Plt _____ WBC _____
 Chest X-ray: Pos Neg Not done
 Findings: _____
 Chest CT: Pos Neg Not done
 Findings: _____
 Lumbar puncture: Pos Neg Not done
 Findings: _____

Other pertinent labs (LFTs, MRI/CT, etc.) _____

Microbiologic Tests [attach copy of microbiology reports]:

Method of influenza detection (check all that apply):
 Rapid influenza test (EIA) IFA/DFA PCR
 Viral culture Other, specify _____
 Influenza type, if known: Influenza A Influenza B Unk
 Rapid RSV test result Pos Neg Not done
 Other viral/bacterial pathogens detected? Yes No Unk
 If yes, specify source: Sputum ET asp BAL
 Pleural fluid Blood Other _____
 If yes, specify pathogen: _____
 Other micro results: _____

Clinical course:

Antivirals (if any), type and dates:

 If hospitalized, intubated? Yes No Unk
 Died: Yes* No Unk
 *If yes, complete Pediatric Death Supplemental Form

Physician/Infection Control Practitioner Contact Info:

Name: _____
 Facility: _____
 Phone/Pgr: _____ E-mail: _____

Please forward any available medical records (e.g. H & P, micro reports, discharge summary, autopsy report). Your assistance with further laboratory characterization/strain-typing of cases with atypical or severe complications (e.g. encephalitis, myocarditis, multi-organ failure) is urgently needed. Please contact your local health department or CDPH to report these cases ASAP so that we can assist with collection and shipment of specimens.

TO REPORT A CASE, PLEASE CONTACT Shanna Cronan at (415) 473-7805 AND FAX THIS FORM TO: (415) 473-6002