



<b>STATE USE ONLY – DO NOT SEND INFORMATION IN THIS SECTION TO CDC</b>		
Last Name: _____	First Name: _____	County: _____
Address: _____	City: _____	State, Zip: _____

<b>Patient Demographics</b>			
1. State: _____	2. County: _____	3. State ID: _____	4. CDC ID: _____
5. Age: _____ <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Years	6. Date of birth: ____/____/____ MM DD YYYY	7. Sex: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	8. Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
9. Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Unknown			

<b>Death Information</b>		
10. Date of illness onset: ____/____/____ MM DD YYYY	11. Date of death: ____/____/____ MM DD YYYY	12 a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 12 b. Were pathology specimens sent to CDC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
13 a. Did cardiac/respiratory arrest occur outside the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
13 b. 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): _____		

<b>Influenza Testing (check all that were used)</b>			
Test Type	Result		Specimen Collection Date
<input type="checkbox"/> Commercial rapid diagnostic test	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza A/B (Not Distinguished)	<input type="checkbox"/> Influenza B <input type="checkbox"/> Negative	____/____/____
<input type="checkbox"/> Viral culture	<input type="checkbox"/> Influenza A (Subtyping Not Done) <input type="checkbox"/> Influenza A (Unable To Subtype)	<input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <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 A/B	<input type="checkbox"/> Influenza B <input type="checkbox"/> Negative	____/____/____
<input type="checkbox"/> Indirect fluorescent antibody (IFA)	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza A/B	<input type="checkbox"/> Influenza B <input type="checkbox"/> Negative	____/____/____
<input type="checkbox"/> Enzyme immunoassay (EIA)	<input type="checkbox"/> Influenza A (Subtyping Not Done) <input type="checkbox"/> Influenza A (Unable To Subtype)	<input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <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 A (Unable To Subtype)	<input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <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	____/____/____

Please fax this form to the Marin County Health Department at (415) 473-6002. For questions, please contact Shanna Cronan at (415) 473-7805.



<b>Culture confirmation of INVASIVE bacterial pathogens</b>		
14 a. Was a specimen collected for bacterial culture from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</span>		
14 b. 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		
14 c. What was the result of the bacterial culture?		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
14 d. If positive, please check the organism cultured.		
<input type="checkbox"/> <i>Streptococcus pneumoniae</i>	<input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin <b>sensitive</b>	<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 <b>resistant (MRSA)</b>	<input type="checkbox"/> Group A streptococcus
<input type="checkbox"/> <i>Haemophilus influenzae</i> not-type b	<input type="checkbox"/> <i>Staphylococcus aureus</i> , <b>sensitivity not done</b>	<input type="checkbox"/> Other invasive bacteria: _____

<b>Culture confirmation of bacterial pathogens from NON-STERILE SITES</b>		
14 e. Were other respiratory specimens collected for bacterial culture (e.g., sputum, ET tube aspirate)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</span>		
14 f. 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		
14 g. What was the result of the bacterial culture?		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
14 h. If positive, please check the organism cultured.		
<input type="checkbox"/> <i>Streptococcus pneumoniae</i>	<input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin <b>sensitive</b>	<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 <b>resistant (MRSA)</b>	<input type="checkbox"/> Group A streptococcus
<input type="checkbox"/> <i>Haemophilus influenzae</i> not-type b	<input type="checkbox"/> <i>Staphylococcus aureus</i> , <b>sensitivity not done</b>	<input type="checkbox"/> Other bacteria: _____

<b>Medical Care</b>	
15. Did the patient receive medical care for this illness before admission to the hospital or death if outside the hospital?	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown
16. <b>If YES*</b> , indicate level(s) of care received (check all that apply):	<input type="checkbox"/> Outpatient clinic <input type="checkbox"/> ER <input type="checkbox"/> Inpatient ward <input type="checkbox"/> ICU
17. Did the patient require mechanical ventilation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown



### Clinical Diagnoses and Complications

18 a. Did complications occur during the acute illness:  Yes  No  Unknown

18 b. If yes, check all complications that occurred during the acute illness:

- Pneumonia (Chest X-Ray confirmed)     Acute Respiratory Disease Syndrome (ARDS)     Croup     Seizures
- Bronchiolitis     Encephalopathy/encephalitis     Reye syndrome     Shock
- Another viral co-infection: \_\_\_\_\_     Other: \_\_\_\_\_     Sepsis

19 a. Did the child have any medical conditions that existed before the start of the acute illness:  Yes  No  Unknown

19 b. If yes, check all medical conditions that existed before the start of the acute illness:

- Moderate to severe developmental delay     Hemoglobinopathy (e.g. sickle cell disease)     Asthma/ reactive airway disease
- Diabetes mellitus     History of febrile seizures     Seizure disorder     Cystic fibrosis
- Cardiac disease (specify) \_\_\_\_\_     Renal disease (specify) \_\_\_\_\_     Skin or soft tissue infection
- Chronic pulmonary disease (specify) \_\_\_\_\_     Immunosuppressive condition (specify) \_\_\_\_\_
- Metabolic disorder (specify) \_\_\_\_\_     Neuromuscular disorder (including cerebral palsy) (specify) \_\_\_\_\_
- Pregnant (specify gestational age) \_\_\_\_\_ weeks     Other (specify) \_\_\_\_\_

### Medication and Therapy History

20 a. Was the patient receiving any of the following therapies in the 7 days prior to illness onset or after illness onset? (check all that apply)

- Aspirin or aspirin-containing products
- NSAID or NSAID-containing products

20 b. Was the patient receiving any of the following therapies prior to illness onset? (check all that apply)

- Antibiotic therapy
- Antiviral therapy specify \_\_\_\_\_
- Chemotherapy or radiation therapy
- Steroids by mouth or injection
- other immunosuppressive therapy: \_\_\_\_\_

### Influenza vaccine history

21. Did the patient receive any influenza vaccine during the current season (before illness)  Yes\*  No  Unknown

22. If YES\*, please specify influenza vaccine received before illness onset:  Trivalent inactivated influenza vaccine (TIV) [injected]  Live-attenuated influenza vaccine (LAIV) [nasal spray]  Unknown

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

- 1 dose ONLY     <14 days prior to illness onset    Date dose given: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 ≥14 days prior to illness onset    MM    DD    YYYY
- 2 doses     2<sup>nd</sup> dose given <14 days prior to onset    Date of 1<sup>st</sup> dose: \_\_\_\_/\_\_\_\_/\_\_\_\_    Date of 2<sup>nd</sup> dose: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 2<sup>nd</sup> dose given ≥14 days prior to onset    MM    DD    YYYY    MM    DD    YYYY

24. Did the patient receive any influenza vaccine in previous seasons?  Yes  No  Unknown

Submitted By: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Phone No.: (\_\_\_\_) \_\_\_\_\_ MM    DD    YYYY  
E-mail Address: \_\_\_\_\_

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-0007).