Pediatric severe influenza illness form (< 18 years old)
2003-04 Season

State case ID: _____ CDC case ID: _____

PLEASE INDICATE COMPLICATIONS/OUTCOMES APPLICABLE TO THIS PATIENT:

☐ **Influenza-Associated Death** (Complete pages 1-4)
☐ **Nonfatal Encephalopathy/Encephalitis** (Complete pages 1-3, and 5-6)
☐ **Encephalopathy and Death** (Complete pages 1-6)

State/Local Health Department contact information

First name: _____ Last name: _____
Title: _____ Institution: _____
City: _____ State: _____
Phone: _____ Fax: _____
E-mail: _____

Patient demographics

1. Patient Name (or initials) _____
2. Date of birth ……. _____/ _____/ _____ (mm/dd/yyyy)
3. Gender……. ☐ Male ☐ Female
4. Race……. ☐ White ☐ Black ☐ Asian ☐ Hawaiian/ Pacific Islander ☐ American Indian/ Alaska Native
5. Ethnicity……. ☐ Hispanic or Latino ☐ Not Hispanic or Latino
6. Place of residence…… City: _____ County: _____
State: _____ Country: _____

Illness course

1. Date of illness onset:….. _____/ _____/ _____
2. Date of fever onset:…… _____/ _____/ _____
(Temperature ≥100.4 ºF or ≥38.0 ºC; or feverishness if not measured)

Symptoms and Signs

1. What symptoms and signs did the patient have during the course of illness? **(check all that apply)**

☐ Feverishness ☐ Fever (≥100.4 ºF **or** ≥38.0 ºC) ☐ Runny nose/congestion ☐ Sore throat
☐ Headache ☐ Cough ☐ Difficulty breathing ☐ Bloody respiratory secretions
☐ Muscle aches ☐ Vomiting ☐ Diarrhea ☐ Abdominal pain
☐ Lethargy ☐ Seizure(s) ☐ Other: (specify): _____

Medical Care

1a. Was the patient evaluated by a health care provider or admitted for medical care? …… ☐ Yes ☐ No

1b. **If YES,** indicate level(s) of care received (check all that apply): ☐ Outpatient clinic ☐ ER ☐ Inpatient ward ☐ Intensive care unit

1c. **If YES,** specify medical facilities where patient was evaluated and/or admitted: (*if > 2 facilities, add information at end of form*)

Facility 1: _____ Date of admission: _____/ _____/ _____
City: _____ State: _____ Date of discharge: _____/ _____/ _____
Facility 2: _____ Date of admission: _____/ _____/ _____
City: _____ State: _____ Date of discharge: _____/ _____/ _____

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Existing medical conditions and medication history

1. Did the patient have any underlying medical conditions?……. ☐ Yes ☐ No

2. **If YES, check all that apply:**

☐ Asthma/ reactive airway disease
☐ Other Chronic lung disease (specify): _____
☐ Cardiac disease (specify): _____
☐ Immunosuppressive condition (specify):_____
☐ Cystic fibrosis
☐ Pregnant (specify gestational age in weeks):_____
☐ Developmental delay
☐ History of febrile seizures before current illness
☐ Diabetes mellitus (Insulin dependent)
☐ Seizure disorder requiring anti-seizure medications
☐ Hemoglobinopathy (e.g. sickle cell disease, not trait)
☐ Renal disease (specify): _____
☐ Other (specify): _____

3. Was the patient receiving any of the following medications when influenza illness started? **(check all that apply)**

☐ Aspirin or aspirin-containing products
☐ Systemic steroids (not inhaled)
☐ Chemotherapy for cancer
☐ Other immunosuppressive medications (specify): _____

Clinical diagnoses and complications

1. What complications, if any, did the patient have during the illness? **(check all that apply):**

☐ Pneumonia (Chest XRay confirmed) ☐ ARDS ☐ Rhabdomyolysis ☐ DIC
☐ Bronchiolitis ☐ Myocarditis ☐ Seizures ☐ Hypotension
☐ Croup ☐ Renal failure ☐ Encephalopathy/encephalitis ☐ Inotropic drugs for Blood Pressure
☐ Mechanical ventilation (intubated) ☐ Myositis ☐ Reye syndrome ☐ Dehydration requiring IV fluids
☐ Fever (highest Temperature = _____ ºC; or _____ºF) ☐ Hypothermia (lowest Temperature = _____ºC; or _____ºF)
☐ Exacerbation of underlying medical condition(s) (specify): _____
☐ Other complications (specify): _____

Additional information:

Culture confirmation of secondary bacterial pathogens

1. Was there **culture confirmation of a bacterial infection**?…… ☐ Yes ☐ No

2. **If YES, specify the organism(s) identified:**

☐ *Streptococcus pneumoniae*
☐ *Staphylococcus aureus,* methicillin **sensitive**
☐ Group A streptococcus
☐ *Staphylococcus aureus,* methicillin **resistant**
☐ *Haemophilus influenzae* type b
☐ *Neisseria meningitidis (serogroup if known):*_____
☐ *Haemophilus influenzae* not-type b
☐ Other (specify) _____

3. **Specify the sites in which the organism(s) were identified (check all that apply)**:

☐ Blood ☐ Cerebrospinal fluid (CSF) ☐ Pleural fluid
☐ Lower respiratory tract (e.g., sputum, endotracheal aspirate, BAL) ☐ Upper respiratory tract (e.g., oropharynx, nasopharynx)
☐ Tissue (specify): _____ ☐ Other (specify): _____

4. Is a bacterial isolate available for further testing by CDC?..... ☐ Yes ☐ No

Non-influenza and Non-bacterial infections (viruses and fungal infections)

1. Was there laboratory testing evidence for a **viral** infection (***not influenza***) or **fungal** infection? ☐ Yes ☐ No

2. **If YES**, please specify what virus or fungal infection and specimen source: _____

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POSITIVE Laboratory Testing Results for Influenza (respiratory specimens)

1. How was the diagnosis of influenza confirmed? **(check all positive influenza tests)**:

☐ Direct fluorescent antibody (DFA) ☐ Rapid antigen test ☐ Viral culture

☐ Enzyme immunoassay (EIA) ☐ RT-PCR

2. Date of first positive influenza test: …… _____/ _____/ _____ List respiratory specimen type: _____

3. If rapid antigen test was positive for influenza, specify kind of influenza test and name if known: _____

☐ Detects influenza A only

☐ Detects influenza A and B, but ***does not differentiate*** the two types (A/B)

☐ Detects influenza A and B ***and differentiates*** the two types

4. Influenza virus identification:

Type: ☐ Influenza **A** ☐ Influenza **B** ☐ **A/B** (Not distinguished) ☐ Type unknown

Influenza A subtype (e.g. H3N2) (specify if known):_____

5. If an influenza virus was isolated from this patient, was the isolate sent to CDC?.....☐ Yes ☐ No

Influenza Vaccine History

1a. Did the patient receive influenza vaccine during the 2003-04 season (***before illness***)? ☐ Yes ☐ No

If YES, please answer 1b-1d.:

1b. Please specify influenza vaccine received before illness: ☐ Trivalent inactivated influenza vaccine (TIV) *[injected]*

☐ Live-attenuated influenza vaccine (LAIV) *[nasal spray]*

1c. How many doses did the patient receive during the 2003-04 season (***before illness***)?. ☐ 1 dose ☐ 2 doses

1d. Specify influenza vaccination dates:

Dose 1: Date: _____/ _____/ _____ ☐ <14 days prior to illness ☐ ≥14 days prior to illness

Dose 2: Date: _____/ _____/ _____ ☐ <14 days prior to illness ☐ ≥14 days prior to illness

2. Did the patient ever receive influenza vaccine in a previous season?…… ☐ Yes ☐ No

Influenza Treatment

1a. Did the patient receive treatment with an antiviral medication for influenza?..... ☐ Yes ☐ No

If YES, please answer 1b-1d.:

1b**.** How many days did the patient receive antiviral treatment? (Leave blank if not applicable) _____ days

1c. What date was antiviral treatment for influenza started?..... …Date: _____/ _____/ _____

1d. Indicate which antiviral medication(s) were received for treatment:

☐ Amantadine (Symmetrel) ☐ Rimantadine (Flumadine)

☐ Oseltamivir (Tamiflu) ☐ Zanamivir (Relenza)

2. If the patient was treated at home with any of the following during the illness, please check the applicable box(es)?

☐ Aspirin ☐ NSAIDs (e.g. ibuprofen; specify):__ _____

☐ Herbal remedies (specify)_____ ☐ Pepto-Bismol

☐ Other OTC medications (acetaminophen, decongestants, cough suppressants; specify)_____

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FATAL CASES REPORT FORM

REPORTING CRITERIA: All deaths associated with laboratory-confirmed influenza (including rapid influenza testing) (Children <18 years old)

DO NOT COMPLETE THIS SECTION UNLESS YOU ARE REPORTING A DEATH MEETING THESE CRITERIA.

Autopsy and Death information

1. Date of death…… _____/ _____/ _____

2a. Was an autopsy performed? ……. ☐ Yes ☐ No

If YES:

2b. Specify the date of autopsy…… _____/ _____/ _____

2c. Were autopsy tissue specimens sent to CDC? ……☐ Yes ☐ No

2d. Was any influenza testing done at autopsy before submission specimens to CDC?.....☐ Yes ☐ No

2e. Specify any positive tests for influenza on respiratory specimens from autopsy (nasopharyngeal, tracheal):

☐ DFA ☐ Rapid antigen test ☐ RT-PCR ☐ Viral culture

3. Did this case have any laboratory testing evidence of influenza virus infection **before autopsy**?.....☐ Yes ☐ No

4. Location where death occurred: (check one)

☐ Emergency Department (pulse initially present) ☐ Inpatient ward

☐ Home (no pulse present at home) ☐ Intensive care unit

☐ Other (specify): _____

Pathologist/ Medical Examiner contact information

First name: _____ Last name: _____

Title: _____ Institution: _____

City: _____ State: _____

Phone: _____ Fax: _____

E-mail: _____

PLEASE PROVIDE:

1) **Clinical Discharge Summary (include admission history and exam), and Laboratory results (if evaluated at a health care facility); AND**
2) **Autopsy Report**

FAX FORMS, CLINICAL AND AUTOPSY INFORMATION TO: 1-888-232-1322

DIRECT QUESTIONS TO 1-800-232-4636 or EOCinfluenza@cdc.gov

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ENCEPHALOPATHY CASE REPORT FORM

REPORTING CRITERIA (Must fulfill all of the following):

- ☐ **Patient <18 years old**
- ☐ **Presence of : Encephalopathy (altered mental status with or without seizures, or personality change, of duration >24 hours)**
- ☐ **Onset of encephalopathy/seizures within 5 days of acute febrile illness**
- ☐ **Laboratory or rapid diagnostic test evidence of acute influenza virus infection**

IF ANY OF THE ABOVE CRITERIA ARE NOT MET, STOP (DO NOT REPORT THE CASE)

Illness

1. Date of onset of first neurologic symptoms…… _____/ _____/ _____
2. What was the duration of altered mental status?: _____days

3a. Did the patient have a seizure?.....☐ Yes ☐ No

If YES

3b. Did the patient have a single seizure or multiple seizures?.....☐ Single ☐ Multiple

3c. Was the patient admitted for status epilepticus?.....☐ Yes ☐ No

3d. Did the patient ever have seizures with a fever before (febrile seizures)?.....☐ Yes ☐ No

3e. Did the patient have a seizure disorder not related to fevers (epilepsy) ?..... ☐ Yes ☐ No

3f. Approximately how long did the longest seizures last (specify time in minutes or hours): _____

3g. Did the patient receive anti-seizure medications?.....☐ Yes ☐ No

3h. Was the patient placed into a medication-induced coma for seizure control?...☐Yes ☐ No

4. Was a Glasgow Coma Score on admission available? ☐ Yes ☐ No If YES, list GCS score: _____

Symptoms and Signs present at any time during illness (check all that apply):

☐ **Altered mental status or Personality change**

☐ Nuchal rigidity ☐ Bulging fontanelle ☐ Papilledema

☐ Ataxia/instability, loss of balance ☐ Coma ☐ Primitive reflexes (e.g. Babinski)

☐ Behavioral/psychiatric symptoms Describe …….

☐ Focal neurologic deficit Describe: ……..

☐ Cranial nerve abnormality Describe: ……..

☐ Movement disorder Describe: ……..

☐ Other neurologic observations (describe):_____

Neuroimaging and Neurodiagnostic testing (Complete all that apply below and please send a copy of all reports)

1a. Was a **Head CT** done? ☐ Yes ☐ No

1b. If **YES**, check all that apply: ☐ Contrast ☐ Non Contrast ☐ Normal ☐ Abnormal Date of CT: ___/ ____/ _____

1c. If Abnormal, specify: _____

2a. Was a **Brain MRI** done? ☐ Yes ☐ No

2b. If **YES**, check all that apply: Results: ☐ Normal ☐ Abnormal Date of MRI: ____/ ____/ _____

2c. If Abnormal, specify: _____

3a. **Was an Electroencephalogram (EEG)** done? ☐ Yes ☐ No

3b. If **YES**, check all that apply: Results: ☐ Normal ☐ Abnormal Date of EEG: ____/ ____/ _____

If Abnormal, specify: _____

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ENCEPHALOPATHY CASE REPORT FORM

Cerebrospinal fluid (CSF) results

1a. Was CSF obtained? ☐ Yes ☐ No **If YES**, Date CSF obtained: _____/ _____/ _____

1b. **If YES**, please complete all of the following:

CSF WBC:_____/mm^3 CSF % PMN: _____ CSF % Lymph:_____ CSF RBC: _____/mm^3

CSF Protein: _____ mg/dL CSF Glucose: _____ mg/dL CSF Gram Stain result: _____

CSF Viral culture result: _____ CSF Bacterial culture result: _____

2. If CSF was obtained, was CSF from this patient sent to CDC? ☐ Yes ☐ No

Admission laboratory results

WBC:_____ % Neutrophils: _____ % Bands: _____ % Lymphocytes _____ Platelets _____

Sodium:_____ Potassium:_____ Bicarbonate:_____ Glucose:_____ BUN:_____ Creatinine:_____

Toxicology screen results (if done):_____

Salicylate level (if done): _____

Other lab results during illness (highest values recorded):

Ammonia: _____ AST (SGOT):_____ ALT (SGPT): _____ LDH:_____ CPK:_____

Neurologic outcome of illness at discharge from medical facility (check one)

☐ **Alive, no neurologic sequelae** ☐ **Alive, neurologic sequelae present** ☐ **Died**

If neurological sequelae at discharge, (describe):_____

_____

Discharge diagnoses (list all)

_____ _____ _____

_____ _____ _____

PLEASE PROVIDE: Clinical Discharge Summary (include admission history and exam), Laboratory results, CT, MRI, and EEG reports.

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Additional information: