



# Novel Influenza A (H1N1) Case Report Form (Hospitalized and Fatal Cases)



COUNTY: \_\_\_\_\_ VCMR ID: \_\_\_\_\_ CDPH ID: CA

- Patients must have:**
- 1) a clinical syndrome consistent with influenza or its complications;
  - 2) either probable or confirmed novel influenza A (H1N1) by laboratory testing;
  - 3) been either hospitalized 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	Hospital admit date	Discharge date	Intubated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Hospital Name	Medical Record No.																																																																				
<b>Level of medical care (check all that apply):</b> <input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> Emergency Room <input type="checkbox"/> Inpatient Ward <input type="checkbox"/> Intensive Care Unit <input type="checkbox"/> None				<b>Significant past medical history:</b>																																																																					
<b>Symptoms that occurred during current illness (check all that apply):</b> <input type="checkbox"/> Fever ≥ 38° C <input type="checkbox"/> Cough <input type="checkbox"/> Sore throat <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Muscle aches <input type="checkbox"/> Altered mental status <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Apnea <input type="checkbox"/> Seizures <input type="checkbox"/> Other Specify: _____				<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%;">Yes</th> <th style="width: 10%;">No</th> <th style="width: 10%;">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 .....(e.g. seizure disorder, developmental delay/MR, hypoxic encephalopathy, etc)</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>Genetic disorder (e.g. Downs) .....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Immunosuppressive medications (e.g. steroids) .....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Prematurity .....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td colspan="4" style="text-align: center;">If yes, # of weeks gestation: _____</td></tr> <tr><td>Gastrointestinal disease (e.g. GE reflux) .....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Pregnancy.....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td colspan="4" style="text-align: center;">If yes, specify # of weeks: _____</td></tr> <tr><td>Other conditions (e.g. obesity) .....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td colspan="4">If Yes for any of the above, please specify: _____</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 .....(e.g. seizure disorder, developmental delay/MR, hypoxic encephalopathy, etc)	<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"/>	Genetic disorder (e.g. Downs) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppressive medications (e.g. steroids) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prematurity .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, # of weeks gestation: _____				Gastrointestinal disease (e.g. GE reflux) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify # of weeks: _____				Other conditions (e.g. obesity) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes for any of the above, please specify: _____			
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<b>Complications that occurred during acute illness(check all that apply):</b> <input type="checkbox"/> Pneumonia/ARDS <input type="checkbox"/> Bronchiolitis <input type="checkbox"/> 2° bacterial pneumonia <input type="checkbox"/> Encephalitis/encephalopathy <input type="checkbox"/> Myocarditis <input type="checkbox"/> Sepsis/Multi-Organ Failure <input type="checkbox"/> Other Specify: _____																																																																									
<b>Antibiotics/antivirals received (if any) and dates:</b> _____																																																																									
<b>Outcome?</b> <input type="checkbox"/> Died <input type="checkbox"/> Recovered <input type="checkbox"/> Unk If died, date of death : ____/____/____																																																																									

**VACCINE HISTORY**

Was patient vaccinated for influenza this season (at least 14 days prior to onset of symptoms)  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]

If yes \*, how many doses did the patient receive?  1 dose  2 doses

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

**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: \_\_\_\_\_

Patient name (last, first) \_\_\_\_\_ Date of Birth \_\_\_\_\_ VCMR ID: \_\_\_\_\_

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**DIAGNOSTIC TESTS (Continued)**

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

Rapid Influenza Test:  Yes\*  No  Unk If yes\*,  Positive  Negative

Influenza diagnosed by other methods (check all that apply):  IFA/DFA  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: \_\_\_\_\_

Other micro results: \_\_\_\_\_

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**EPIDEMIOLOGIC RISK FACTORS**

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Recent travel?  Yes\*  No  Unk If yes\*, where? \_\_\_\_\_

Recent ill contacts?  Yes\*  No  Unk If yes\*, who? \_\_\_\_\_

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**REMARKS (Please include any available medical records – e.g. H & P, laboratory reports, discharge summary, autopsy report)**

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**CONTACT INFORMATION**

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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