

## DRAFT - 2009 (Novel) Influenza A (H1N1) Virus Case Report Form for Hospitalizations and Deaths – Wisconsin Division of Public Health

### Patient demographic information

Last Name _____ First Name _____ MI ____			
Date of Birth: ____ / ____ / ____ Age _____ (Circle Years/Months/Days)			
Residential Address _____			
City _____		State _____	Zip Code _____
Telephone (____) _____		Employer\school\facility _____	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	Race: <input type="checkbox"/> White <input type="checkbox"/> Black	<input type="checkbox"/> Asian <input type="checkbox"/> Multiracial <input type="checkbox"/> Unknown <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Island <input type="checkbox"/> Other _____

### Hospital and clinical information

Patient medical record number _____	
Hospital name _____	City _____ State ____
Person completing this form _____	Phone number (____) _____
Date of symptom onset (fever or respiratory symptoms) ____ / ____ / ____ (month/day/year)	
Date of first outpatient visit for this illness ____ / ____ / ____	
Date of first ER visit for this illness ____ / ____ / ____	
Date of hospital admission ____ / ____ / ____	
If transferred from another hospital, date of first hospital admission ____ / ____ / ____	
Date of discharge from hospital ____ / ____ / ____	
Clinical signs and symptoms:	
<input type="checkbox"/> Fever	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Chills	<input type="checkbox"/> Cough
<input type="checkbox"/> Fatigue/weakness	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Headache	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Myalgias (muscle aches)	<input type="checkbox"/> Runny nose (rhinorrhea)
<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

### Medical history

<input type="checkbox"/> Obesity BMI if avail _____ OR Height _____ cm / inches Weight _____ lbs / kg
<input type="checkbox"/> Smoking (current or history of) please specify _____
<b>Check all that apply and specify where indicated</b>
<input type="checkbox"/> Pregnancy please specify number of weeks pregnant _____
<input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Other chronic lung disease _____
<input type="checkbox"/> Diabetes Mellitus please specify type <input type="checkbox"/> Type I <input type="checkbox"/> Type II
<input type="checkbox"/> Chronic Cardiovascular disease (excluding HTN) please specify _____
<input type="checkbox"/> Kidney disease please specify _____
<input type="checkbox"/> Cancer in last 12 months please specify _____
<input type="checkbox"/> Neurologic/Neuromuscular condition (incl. seizure disorder, developmental delay) please specify _____
<input type="checkbox"/> Hemoglobinopathy (e.g., sickle cell disease) please specify _____
<input type="checkbox"/> Prematurity (gestational age < 37 weeks at birth for patients < 2 yrs of age): Gestational age at birth, in weeks _____
<input type="checkbox"/> Current Immunosuppressive condition (e.g., HIV, chemotherapy, transplant, corticosteroids) please specify _____
<input type="checkbox"/> Other chronic disease(s) please specify _____

**Illness severity** (During the course of the illness and hospitalization, did the patient require or have)

Chest X-ray or chest CT performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<i>If yes, please check findings:</i>	<input type="checkbox"/> Opacities	<input type="checkbox"/> Pleural effusion	<input type="checkbox"/> Consolidation <input type="checkbox"/> Infiltrates
Mechanical ventilation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Vasopressor or inotropic medications to maintain blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Acute respiratory distress syndrome (ARDS)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Date of ICU admission: ____/____/____	Date transferred out of ICU: ____/____/____		
Outcome? <input type="checkbox"/> Died <input type="checkbox"/> Alive <input type="checkbox"/> Unknown	<i>If died, date of death</i> ____/____/____		

**Medications**

Did patient receive antivirals to treat or prevent influenza, either before or during hospitalization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<i>If yes, circle name and indicate date initiated if known.</i>			
Oseltamivir	Date initiated ____/____/____	Amantadine	Date initiated ____/____/____
Zanamivir	Date initiated ____/____/____	Rimantidine	Date initiated ____/____/____
Did patient receive antibacterial medications during the first five days of hospitalization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<i>If yes, date initiated:</i> ____/____/____			

**Laboratory test results**

Date first influenza-positive specimen was collected?	____/____/____		
Results <i>check all that apply</i>	<input type="checkbox"/> (Novel) 2009 influenza A (H1N1)	<input type="checkbox"/> Seasonal influenza A (H1)	
	<input type="checkbox"/> Unsubtypeable influenza A (not human H1 or H3)	<input type="checkbox"/> Seasonal influenza A (H3)	
	<input type="checkbox"/> Influenza A, subtyping not performed	<input type="checkbox"/> Seasonal influenza B	
		<input type="checkbox"/> Rapid antigen influenza A or B	
Were bacterial cultures performed during the first five days of hospitalization?:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<i>If any were positive, please fill out table below.</i>			
Specimen type (blood, etc)	Date collected	Organism	

**Vaccination history**

Did the patient receive influenza vaccine between July 2008 and 2 weeks prior to hospitalization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<i>If yes, specify:</i>	<input type="checkbox"/> Seasonal influenza vaccine <i>mo/yr</i> ____/____	<input type="checkbox"/> 2009 (novel) H1N1 vaccine <i>mo/yr</i> ____/____	
Did the patient ever receive pneumococcal vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

**Comments**

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