



Pediatric Severe Influenza Case History Form

Patients must be: 1) 0-17 years; 2) have confirmed influenza by laboratory testing; and 3) have been hospitalized in the PICU 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 | Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | Admit date | Medical record no. | Hospital Name | | | | |
| Level of medical care (check all that apply): <input type="checkbox"/> Outpatient clinic <input type="checkbox"/> Emergency Room <input type="checkbox"/> Inpatient ward <input type="checkbox"/> Pediatric Intensive Care Unit <input type="checkbox"/> None | | | Significant past medical history: | | | Yes | No | Unk |
| Symptoms that occurred during the current illness (check all that apply): <input type="checkbox"/> Fever ($\geq 38^\circ\text{C}$) <input type="checkbox"/> Seizures <input type="checkbox"/> Apnea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Altered consciousness <input type="checkbox"/> Lower respiratory (cough, shortness of breath, wheezing, bronchospasm) <input type="checkbox"/> Other Specify: _____ | | | Cardiac disease..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Complications that occurred during the acute illness (check all that apply): <input type="checkbox"/> Pneumonia/ARDS <input type="checkbox"/> Secondary bacterial pneumonia <input type="checkbox"/> Croup <input type="checkbox"/> Bronchiolitis <input type="checkbox"/> Myocarditis <input type="checkbox"/> Reye Syndrome <input type="checkbox"/> Encephalitis/encephalopathy <input type="checkbox"/> Sepsis/Multi-organ Failure <input type="checkbox"/> Other Specify: _____ | | | Chronic pulmonary disorder (e.g. Asthma, cystic fibrosis) | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Antibiotics/antivirals received (if any) and dates: _____ | | | Immunosuppression (e.g. HIV, malignancy)..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If hospitalized, intubated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | Metabolic disorder (e.g. diabetes mellitus, renal)..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Outcome? <input type="checkbox"/> Died* <input type="checkbox"/> Recovered <input type="checkbox"/> Unknown *If Died, complete Pediatric Death Supplemental Form | | | Neuromuscular disorder..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | History of febrile seizures..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Seizure disorder..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Developmental delay..... | | | <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"/> |
| | | | Steroids by mouth/injection..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Cancer chemotherapy..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Radiation therapy..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other immunosuppressive medications..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Pregnancy.....If Yes, specify # of weeks _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other conditions..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | If Yes for any of the above, please specify: _____ | | | | | |

VACCINE HISTORY

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

Was the patient vaccinated this season (inactivated or LAIV-FluMist)? Yes No Unknown

If Yes, approximate dates: 1st dose ___/___/___ Inactivated FluMist 2nd dose (if done): ___/___/___ Inactivated FluMist

DIAGNOSTIC TESTS

| | |
|--|---|
| Laboratory studies: CBC: Hct _____ Pit _____ WBC _____ Chest X-ray: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done Findings: _____ Cardiac echo: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done Findings: _____ Lumbar puncture: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done Findings: _____ Other pertinent labs (LFTs, MRI/CT, etc.), if available: _____ | Influenza/Microbiology testing: Rapid influenza test: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done Rapid RSV test: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done If testing confirmed influenza, specify: <input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Not done Blood culture: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done If Pos, pathogen?: _____ Respiratory culture: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done If Pos, specify specimen (n-p swab/wash, o-p swab, ET aspirate, sputum, BAL, pleural fluid) and pathogen: _____ |
|--|---|

CONTACT INFORMATION

| | | | | |
|---|----------|--------------|------------|----------------|
| Physician/Infection Control Practitioner Name | Facility | Pager number | Fax number | E-mail address |
| | | () | () | |

To report a case, contact and fax this form to: Los Angeles County Department of Health Services-Public Health
Acute Communicable Disease Control Phone 213-240-7941 Fax 213-482-4856