



# 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			Neuromuscular disorder.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*If Died, complete Pediatric Death Supplemental Form			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: 1<sup>st</sup> dose \_\_\_/\_\_\_/\_\_\_  Inactivated  FluMist 2<sup>nd</sup> 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: _____	<b>Influenza/Microbiology testing:</b> 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: _____
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## CONTACT INFORMATION

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