WEDSS ID _____

Case Report Form for (Novel) 2009 Influenza A (H1N1) Virus Hospitalizations or Deaths – Wisconsin Division of Public Health – Sep 18, 2009

Use this form to report hospitalizations or deaths in persons with confirmed or probable (novel) 2009 influenza A (H1N1) virus infection. Please fax completed form to the local health department or to the Wisconsin DPH at FAX:608-261-4976 or FAX:608-266-2906 or enter information into WEDSS.

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 _____

Sex: ☐ Male ☐ Female	If female, Pregnant? ☐ Yes ☐ No ☐ Unknown	If pregnant, estimated delivery date _____/_____/_____
	Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown	Race: ☐White ☐ Asian ☐ Native American ☐ Native Hawaiian/Pacific Island ☐ Black ☐ Multiracial ☐ Unknown ☐ Other_____

Hospital information, onset, death

Patient medical record number _____

Hospital name _____ City _____ State __ __

Person completing this form _____ Phone number (_____) _____-_____

Date of hospital admission _____/_____/_____

Date of discharge from hospital _____/_____/_____

Date of symptom onset (fever or respiratory symptoms) _____/_____/_____

Patient died of this illness ☐Yes ☐ No *If died*, date of death _____/_____/_____

Laboratory results

Date first influenza-positive specimen was collected? _____/_____/_____

Laboratory where test was performed _____

Result (check if positive) ☐ (Novel) 2009 influenza A (H1N1)

☐ Unsubtypeable influenza A (not human H1 or H3)

☐ Influenza A, subtyping not performed (Please do not include Rapid Antigen test results)

Were bacterial cultures performed during the first five days of hospitalization?: ☐ Yes ☐ No ☐ Unknown

If any positive, please fill out table below.

Site (blood, CSF, etc)	Date collected	Organism

Clinical information

Date of first outpatient visit for this illness _____/_____/_____

Date of first ER visit for this illness _____/_____/_____

Hospitalized for < 24 hours? ☐Yes ☐ No ☐ Unknown

Transferred from another hospital? ☐Yes ☐ No ☐ Unknown Name of hospital _____

If transferred from another hospital, date of first hospital admission _____/_____/_____

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Presenting clinical signs and symptoms

- ☐ Fever
- ☐ Chills
- ☐ Fatigue/weakness
- ☐ Headache
- ☐ Runny nose (rhinorrhea)
- ☐ Nasal congestion
- ☐ Sore throat
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Myalgias (muscle aches)

Other symptoms

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

Chest X-ray or chest CT during first 5 days in hospital? ☐ Yes ☐ No ☐ Unknown

If yes, please check findings: ☐Normal ☐ Infiltrates ☐ Opacities ☐ Consolidation ☐ Pleural effusion

ICU admission? (date) ____/____/____ | Date transferred out of ICU: ____/____/____

Mechanical ventilation?	☐ Yes	☐ No	☐ Unknown
Vasopressor or inotropic medications to maintain blood pressure?	☐ Yes	☐ No	☐ Unknown
Acute respiratory distress syndrome (ARDS)?	☐ Yes	☐ No	☐ Unknown
Acute renal failure requiring dialysis? (not end-stage renal disease)	☐ Yes	☐ No	☐ Unknown

Medications

Did patient receive antivirals to treat or prevent influenza, either before or during hospitalization? ☐ Yes ☐ No ☐ Unknown

If yes, circle name and indicate date initiated if known.

- ☐ Oseltamivir (Tamiflu) Date initiated ____/____/____
- ☐ Zanamivir (Relenza) Date initiated ____/____/____
- ☐ Amantadine (Symmetel) Date initiated ____/____/____
- ☐ Rimantidine (Flumadine) Date initiated ____/____/____

Did patient receive antibacterial medications during the first five days of hospitalization? ☐ Yes ☐ No ☐ Unknown

If yes, date initiated: _____ / _____ / _____

Medical history

☐ Obesity *BMI if avail* _____ OR Height _____ *cm / inches* Weight _____ *lbs / kg*

☐ Smoking *(current or history of) please specify* _____

Check all that apply and specify where indicated ☐ No underlying conditions

- ☐ Asthma
- ☐ COPD
- ☐ Other chronic lung disease _____
- ☐ Diabetes Mellitus *Please specify type* ☐ Type I ☐ Type II
- ☐ Chronic Cardiovascular disease (excluding HTN) *please specify* _____
- ☐ Kidney disease *please specify* _____
- ☐ Cancer in last 12 months *please specify* _____
- ☐ Neurologic/Neuromuscular condition (incl. seizure disorder, developmental delay) *please specify*_____
- ☐ Hemoglobinopathy (e.g., sickle cell disease) *please specify* _____
- ☐ Patient < 2 years of age, born premature Gestational age at birth, in weeks _____
- ☐ Current Immunosuppressive condition (e.g., HIV, chemotherapy, transplant, corticosteroids) *please specify* _____
- ☐ Other chronic disease(s) *please specify* _____

Vaccination history

Check if patient has received influenza vaccine since July 2008 and at least 2 weeks prior to hospitalization?

If yes, specify:
- ☐ Seasonal influenza vaccine Date (can approximate) _____/_____/_____
- ☐ 2009 (novel) H1N1 vaccine Date (can approximate) _____/_____/_____

Did the patient ever receive pneumococcal vaccine? ☐ Yes ☐ No ☐ Unknown

Comments:

Sign and date _____