

This form should be faxed to: (951) 358-5102

SEVERE INFLUENZA CASE HISTORY FORM (ICU AND FATAL CASES AGE 0-64 YEARS)

CASE STATUS (check all that apply)			
<input type="checkbox"/> ICU A case with laboratory-confirmed influenza requiring admission to an intensive care unit (ICU)			
<input type="checkbox"/> Fatal A case with laboratory-confirmed influenza that has died at any location (e.g. hospital, emergency, home)			
PATIENT INFORMATION			
Last name		First name	
Street address		City	Zip code
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		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"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Date of birth	
Local health jurisdiction of residence		Date of hospital admission	
ONSET, VACCINATION HISTORY, HOSPITALIZATION AND DEATH INFORMATION			
Date of onset of symptoms	Received this season's influenza vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date received: Dose 1	Dose 2
If hospitalized, hospital name and location		Date of hospital admission	Date of hospital discharge
If died, date of death	If died, location of death (i.e. home, ED-name of hospital ED, etc.)		If died, autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
INFLUENZA LABORATORY TESTING INFORMATION (Please attach a copy of the test result, if available)			
Date of specimen collection	Specimen type (e.g. nasopharyngeal swabs, endotracheal aspirate, bronchoalveolar lavage)		
Influenza type and/or subtype Influenza A: <input type="checkbox"/> (H3) <input type="checkbox"/> (2009H1N1) <input type="checkbox"/> (A Unknown – PCR) <input type="checkbox"/> (A Unknown – rapid test, culture or DFA) <input type="checkbox"/> (A – PCR unsubtypeable (i.e. novel)) Influenza B: <input type="checkbox"/> (Yamagata) <input type="checkbox"/> (Victoria) <input type="checkbox"/> (B Unknown)			Where was testing performed?
REPORTING AGENCY INFORMATION			
Reporting local health jurisdiction	Name of reporter	Telephone number of reporter	
CLINICAL COURSE			
Received antiviral treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Type of antiviral <input type="checkbox"/> Oseltamivir <input type="checkbox"/> Zanamivir <input type="checkbox"/> Other Specify other: _____		
Date antiviral treatment started	Date antiviral treatment ended	Intubated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Complications <input type="checkbox"/> Pneumonia <input type="checkbox"/> ARDS <input type="checkbox"/> Sepsis <input type="checkbox"/> Acute renal failure <input type="checkbox"/> Encephalitis/encephalopathy <input type="checkbox"/> Required vasopressor <input type="checkbox"/> Required hemodialysis <input type="checkbox"/> Pulmonary embolus <input type="checkbox"/> Secondary bacterial infection If yes, specify organism: _____ <input type="checkbox"/> Other Specify other: _____			
SIGNIFICANT PAST MEDICAL HISTORY			
Did the patient have underlying medical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<input type="checkbox"/> Cardiac disease <input type="checkbox"/> Chronic pulmonary disorder <input type="checkbox"/> Immunosuppression (e.g. cancer) <input type="checkbox"/> Immunosuppressive medications (e.g. chemotherapy, steroids)			
<input type="checkbox"/> Metabolic disorder (e.g. diabetes mellitus, renal) <input type="checkbox"/> Neurological disorder (e.g. cerebral palsy) <input type="checkbox"/> Hemoglobinopathy (e.g. sickle cell disease)			
<input type="checkbox"/> Genetic disorder (e.g. Downs) <input type="checkbox"/> Obesity If obese, BMI (if known): _____ Height: _____ Weight: _____			
<input type="checkbox"/> Pregnant If pregnant, estimated delivery date: _____			
<input type="checkbox"/> Postpartum If postpartum, delivery date: _____ <input type="checkbox"/> Other conditions (e.g. hypertension, hyperlipidemia)			
If yes for any of the above, please specify: _____			
NOTES SECTION (Please attach relevant medical records if available)			

**TO REPORT A CASE, PLEASE CONTACT COUNTY OF RIVERSIDE DISEASE CONTROL AT (951) 358-5107 AND
FAX THIS FORM TO: (951) 358-5102.**

Please forward any available medical records (e.g. H&P, mirco reports, discharge summary, autopsy report) to Disease Control ASAP.