



# Influenza-Associated Pediatric Deaths Case Report Form

Form approved  
OMB No. 0920-0007

## STATE USE ONLY – DO NOT SEND INFORMATION IN THIS SECTION TO CDC

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ County: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State, Zip: \_\_\_\_\_

### Patient Demographics

1. State: _____	2. County: _____	3. State ID: _____	4. CDC ID: _____
5. Age: _____ <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	6. Date of birth: _____/_____/_____ MM DD YYYY	7. Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unkown	8. Ethnicity: <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Unknown
9. Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Unknown			

### Death Information

10. Date of illness onset: _____/_____/_____ MM DD YYYY	11. Date of death: _____/_____/_____ MM DD YYYY	12. Was an autopsy performed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
13 a. Did cardiac/respiratory arrest occur outside the hospital? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
13 b. Location of death: <input type="radio"/> Outside the Hospital (e.g. home or in transit to hospital) <input type="radio"/> Emergency Dept (ED) <input type="radio"/> Inpatient ward <input type="radio"/> ICU <input type="radio"/> Other (specify): _____		
13 c. If the death occurred in the hospital, what was the date of admission? _____/_____/_____ MM DD YYYY		

### CDC Laboratory Specimens

14 a. Were pathology specimens sent to CDC's Infectious Diseases Pathology Branch? Please provide the lab ID No. if known _____	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
14 b. Were influenza isolates or original clinical material sent to CDC's Influenza Division? Please provide the lab ID No. if known _____	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
14 c. Were <i>Staph aureus</i> isolates sent to CDC's Division of Healthcare Quality Promotion? Please provide the lab ID No. if known _____	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown





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## Culture confirmation of bacterial pathogens from NON-STERILE SITES

16 d. Were other **respiratory** specimens collected for bacterial culture (e.g., sputum, ET tube aspirate)? O Yes O No O Unknown

16 e. If yes, please indicate the site from which the specimen was obtained and the result. *If more than one specimen type is positive and more than one organism is identified please indicate the organism cultured from each specimen type in the comments section.*

Specimen Type	Collection Date	Result
<input type="checkbox"/> Sputum	Date ___/___/___	O Positive O Negative O Unknown
<input type="checkbox"/> ET tube	Date ___/___/___	O Positive O Negative O Unknown
<input type="checkbox"/> Other _____	Date ___/___/___	O Positive O Negative O Unknown
<input type="checkbox"/> Unknown		

16 f. If positive, please check the organism cultured.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> <i>Streptococcus pneumoniae</i> | <input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin <b>sensitive</b> (MSSA) | <input type="checkbox"/> <i>Haemophilus influenzae</i> not-type b |
| <input type="checkbox"/> Group A streptococcus           | <input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin <b>resistant</b> (MRSA) | <input type="checkbox"/> <i>Haemophilus influenzae</i> type b     |
| <input type="checkbox"/> Other bacteria: _____           | <input type="checkbox"/> <i>Staphylococcus aureus</i> , <b>sensitivity not done</b>         | <input type="checkbox"/> <i>Pseudomonas aeruginosa</i>            |

*(If reporting another viral co-infection please do so in section 19 Clinical Diagnosis and Complications)*

## Pathology confirmation of bacterial pathogens

16 g. Was a specimen (e.g., fixed lung tissue) collected from an autopsy for testing of bacterial pathogens by a local or state pathologist? *(If pathology results are available from CDC it is not necessary to input those results here, however please make sure to complete section 14 "CDC Laboratory Specimens")* O Yes O No O Unknown

*If yes please indicate the results of these tests in the comments section at the end of the form.*

## Medical Care

17. Did the patient require mechanical ventilation? O Yes O No O Unknown



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## Clinical Diagnoses and Complications

18 a. Did complications occur during the acute illness?       Yes     No     Unknown

18 b. **If yes**, check all complications that occurred during the acute illness:

- Pneumonia (Chest X-Ray confirmed)       Acute Respiratory Disease Syndrome (ARDS)       Croup       Seizures
- Bronchiolitis       Encephalopathy/encephalitis       Reye syndrome       Shock
- Another viral co-infection: \_\_\_\_\_       Other: \_\_\_\_\_

19 a. Did the child have any medical conditions that existed before the start of the acute illness?     Yes     No     Unknown

19 b. **If yes**, check all medical conditions that existed before the start of the acute illness:

- Moderate to severe developmental delay       Hemoglobinopathy (e.g. sickle cell disease)       Asthma/ reactive airway disease
- Diabetes mellitus       History of febrile seizures       Seizure disorder       Cystic fibrosis
- Cardiac disease (specify) \_\_\_\_\_       Renal disease (specify) \_\_\_\_\_       Skin or soft tissue infection (SSTI)
- Chromosomal Abnormality (specify) \_\_\_\_\_       Mitochondrial Disorder (specify) \_\_\_\_\_
- Chronic pulmonary disease (specify) \_\_\_\_\_       Immunosuppressive condition (specify) \_\_\_\_\_
- Metabolic disorder (specify) \_\_\_\_\_       Neuromuscular disorder (including cerebral palsy) (specify) \_\_\_\_\_
- Pregnant (specify gestational age) \_\_\_\_\_ weeks       Other (specify) \_\_\_\_\_

## Medication and Therapy History

20 a. Was the patient receiving any of the following therapies in the 7 days **prior** to illness onset **or after** illness onset? **(check all that apply)**

- Aspirin or aspirin-containing products       NSAID or NSAID-containing products

20 b. Was the patient receiving any of the following therapies **prior** to illness onset? **(check all that apply)**

- Antiviral Prophylaxis       Chemotherapy or radiation therapy       Steroids by mouth or injection       other immunosuppressive therapy: \_\_\_\_\_

20 c. Was the patient receiving any of the following therapies **after** illness onset? **(Check all that apply)**

- Antibiotic therapy specify \_\_\_\_\_       Antiviral therapy specify \_\_\_\_\_



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Influenza Vaccine History			
21. Did the patient receive any influenza vaccine during the current season (before illness)		O Yes	O No O Unknown
22. <b>If YES*</b> , please specify influenza vaccine received before illness onset:		<input type="checkbox"/> Trivalent inactivated influenza vaccine (TIV) [ <i>injected</i> ] <input type="checkbox"/> Live-attenuated influenza vaccine (LAIV) [ <i>nasal spray</i> ] <input type="checkbox"/> Unknown	
23. <b>If YES*</b> , how many doses did the patient receive and what was the timing of each dose? (Enter vaccination dates if available)			
O 1 dose <b>ONLY</b>	<input type="checkbox"/> <14 days prior to illness onset <input type="checkbox"/> ≥14 days prior to illness onset	Date dose given: _____ / _____ / _____ MM DD YYYY	
O 2 doses	<input type="checkbox"/> 2 <sup>nd</sup> dose given <14 days prior to onset <input type="checkbox"/> 2 <sup>nd</sup> dose given ≥14 days prior to onset	Date of 1 <sup>st</sup> dose: _____ / _____ / _____ MM DD YYYY	Date of 2 <sup>nd</sup> dose: _____ / _____ / _____ MM DD YYYY
24 a. Did the patient receive any influenza vaccine in previous seasons?		O Yes	O No O Unknown
24 b. <b>If YES</b> , and patient was ≤8 years of age at the time of death, did they receive 2 doses of vaccine during a previous season?		O Yes	O No O Unknown
Submitted By: _____ Date: _____ / _____ / _____ Phone No.: (____) - _____ MM DD YYYY E-mail Address: _____			

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-0007).