Influenza – Report of Severe Illness (ICU Admission) or Death in Pregnant and PostPartum Women

Centers for Disease Control and Prevention (CDC) and
Kansas Department of Health and Environment (KDHE)

Instructions: Use this form to report all **pregnant and postpartum women** (up to 6 weeks postpartum) **with severe influenza** who were **admitted to an intensive care unit** (ICU) or who **died**.

Complete form and fax to KDHE: 877-427-7318

Note: The CDC has established a support line for CDC guidance for pregnant women via telephone consultation with board-certified OB/GYN: 404-368-2133. This support line is staffed 24 hours per day, seven days per week.

Reporter contact name:	
Reporter contact phone:	
Reporter contact e-mail:	

Case ID:	
Medical record number:	
Hospital name:	
Hospital zip code:	
Patient name:	
Patient DOB:	
City, State, and Zip code of patient residence:	

1. Patient Race:

☐ White
☐ Black/African-American
☐ Asian/Pacific Islander
☐ American Indian/Alaskan Native
☐ Other
☐ Unknown

2. Patient Ethnicity:

☐ Hispanic
☐ Non-Hispanic
☐ Unknown

3. Insurance Type:

☐ Private health insurance
☐ Medicaid
☐ Self-pay
☐ Uninsured
☐ Unknown

4. Pregnancy classified as high-risk? ☐ Yes ☐ No ☐ Unknown

5. Underlying medical conditions/risk factors:

☐ Asthma
☐ Other chronic lung disease
☐ Pre-existing diabetes (prior to pregnancy)
☐ Gestational diabetes
☐ Obesity (prior to pregnancy)
☐ Cardiovascular disease, excluding hypertension
☐ Hypertension (prior to pregnancy)
☐ Gestational Hypertension/Preeclampsia/Eclampsia
☐ Seizure disorder
☐ Neurodevelopmental and/or neuromuscular disorder
☐ Tobacco use during current pregnancy
☐ History of tobacco use
☐ Immunosuppression, specify_________________________
☐ Cancer diagnosed in last year
☐ Hemoglobinopathy
☐ Renal disease
☐ Other, specify:________________
☐ Unknown

6. Prenatal medications upon admission to hospital:

7. Estimated due date? __/__/__ ☐ Unknown
8. Gestational age at admission (wks): ____ ☐ Unknown

9. Date of symptom onset: __/__/__ ☐ Unknown
10. Date initial care sought: __/__/__ ☐ Unknown

11. Did mother receive rapid influenza test? ☐ Yes ☐ No ☐ Unknown
Result of rapid test? ☐ Positive ☐ Negative ☐ Unknown

12. Did mother receive rRT-PCR test? ☐ Yes ☐ No ☐ Unknown
Result of rRT-PCR test? ☐ Positive ☐ Negative ☐ Unknown

13. Did mother have any viral cultures? ☐ Yes ☐ No ☐ Unknown
Result of viral cultures? ☐ Positive ☐ Negative ☐ Unknown

14. Did mother receive DFA/IFA test? ☐ Yes ☐ No ☐ Unknown
Result of DFA/IFA cultures? ☐ Positive ☐ Negative ☐ Unknown

15. Did mother receive any influenza vaccine in 2009 or 2010 more than 2 weeks before onset of illness? ☐ Yes ☐ No ☐ Unknown
If yes, 2009 seasonal flu vaccine? ☐ Yes ☐ No ☐ Unknown
2009 pandemic H1N1 vaccine? ☐ Yes ☐ No ☐ Unknown

16. Did mother take antiviral medications after becoming ill?
☐ Yes (list below) ☐ No ☐ Unknown

□ Oseltamivir (Tamiflu®)	Dose _________ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Zanamivir (Relenza®)	Dose _________ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Rimantadine	Dose _________ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Amantadine	Dose _________ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Other	Dose _________ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Unknown antiviral	

17. Date of hospital admission: __/__/__ ☐ Unknown

18. Admitted to ICU? ☐ Yes ☐ No ☐ Unknown
19. Date of ICU admission: __/__/__ ☐ Unknown
20. Date of Final ICU discharge: __/__/__ ☐ Not yet discharged ☐ Unknown

21. Date of hospital discharge/death: __/__/__ ☐ Not yet discharged ☐ Unknown
22. Maternal death? ☐ Yes ☐ No ☐ Unknown

23. Other medications during hospitalization:
☐ Antibiotics
☐ Antihypertensives
☐ Vasopressors
☐ Systemic corticosteroids. If yes, please specify reason (e.g. for maternal health or fetal lung maturity) ____

☐ Nebulized drugs (e.g. albuterol)
☐ Antiepileptics
☐ Antiglycemics
☐ Tocolytic agents
☐ Diuretics
☐ Other, specify:_______________
☐ Unknown

24. Was she diagnosed with:

Pneumonia ☐ Yes, date: __/__/__ ☐ No ☐ Unknown

If pneumonia, was a bacterial culture obtained? ☐ Yes ☐ No ☐ Unknown

What was the culture site?_______________

Result of bacterial culture? ☐ Positive ☐ Negative ☐ Unknown

ARDS ☐ Yes, date: __/__/__ ☐ No ☐ Unknown

25. Did she require mechanical ventilation?

☐ Yes, then how many days?___ ☐ No ☐ Unknown

26. Date of delivery: ___/___/___ ☐ Unknown

27. Delivery location:

☐ labor and delivery
☐ emergency department
☐ intensive care unit
☐ Other, specify:_______________________________________
☐ Unknown

28. Method of delivery:

☐ Undelivered
☐ Vaginal
☐ Cesarean, scheduled
☐ Cesarean, emergency
☐ Unknown

29. Other delivery details/complications:

30. Outcome:

☐ Live birth
☐ Stillbirth
☐ Unknown

31. Gestational age at delivery (wks): ____

32. Infant birthweight: ________ ☐ Unknown
33. Infant 1-minute Apgar? ____ ☐ Unknown
34. Infant 5-minute Apgar? ____ ☐ Unknown

35. Infant to NICU? ☐ Yes ☐ No ☐ Unknown
36. Date of infant discharge/death: __/__/__ ☐ Unknown
37. Infant death? ☐ Yes ☐ No ☐ Unknown

38. Infant conditions during hospitalization?
- ☐ Skin rash
- ☐ Fever
- ☐ Temperature instability
- ☐ Bradycardia
- ☐ Apnea
- ☐ Petechiae
- ☐ Chorioretinitis
- ☐ Cataracts
- ☐ Seizures
- ☐ Meningitis
- ☐ Other neurologic abnormality, specify:________________________
- ☐ Hearing loss
- ☐ Pneumonia
- ☐ Sepsis
- ☐ Respiratory distress, specify cause: ___________________________
- ☐ Other, specify____
- ☐ Unknown

39. Infant outcome (any details regarding isolation, antivirals, or complications)**:**

40. Narrative (relevant details including rationale for delivery, overall clinical course)**:**