## Influenza-Associated Pediatric Deaths Case Report Form

**LAST NAME**: ___________________________________  **FIRST NAME**: ______________________  **COUNTY**: _____________________

**ADDRESS**:  **CITY**:  **STATE, ZIP**: 

### Patient Demographics

<table>
<thead>
<tr>
<th>1. State:</th>
<th>2. County:</th>
<th>3. State ID:</th>
<th>4. CDC ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>_______</td>
<td>_____ / _____ / _____</td>
<td>O Male/O Female/O Unknown</td>
<td>O Hispanic or Latino/O Not Hispanic or Latino/O Unknown</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>O Days</th>
<th>O Months</th>
<th>O Years</th>
</tr>
</thead>
</table>

### Death Information

<table>
<thead>
<tr>
<th>10. Date of illness onset:</th>
<th>11. Date of death:</th>
<th>12. Was an autopsy performed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ / _____ / _____</td>
<td>_____ / _____ / _____</td>
<td>O Yes/O No/O Unknown</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13 a. Did cardiac/respiratory arrest occur outside the hospital?</th>
<th>13 b. Location of death:</th>
<th>13 c. If the death occurred in the hospital, what was the date of admission?</th>
</tr>
</thead>
<tbody>
<tr>
<td>O Yes/O No/O Unknown</td>
<td>O Outside the Hospital (e.g. home or in transit to hospital)/O Emergency Dept (ED)/O Inpatient ward/O ICU/O Other (specify): ________</td>
<td>_____ / _____ / _____</td>
</tr>
</tbody>
</table>

### CDC Laboratory Specimens

<table>
<thead>
<tr>
<th>14 a. Were pathology specimens sent to CDC’s Infectious Diseases Pathology Branch?</th>
<th>14 b. Were influenza isolates or original clinical material sent to CDC’s Influenza Division?</th>
<th>14 c. Were Staph aureus isolates sent to CDC’s Division of Healthcare Quality Promotion?</th>
</tr>
</thead>
<tbody>
<tr>
<td>O Yes/O No/O Unknown</td>
<td>O Yes/O No/O Unknown</td>
<td>O Yes/O No/O Unknown</td>
</tr>
</tbody>
</table>

Please provide the lab ID No. if known_________
Influenza Testing (check all that were used)

<table>
<thead>
<tr>
<th>Test Type</th>
<th>Result</th>
<th>Specimen Collection Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Commercial rapid diagnostic test</td>
<td>O Influenza A  O Influenza B  O Negative  O Influenza A/B (Not Distinguished)  O 2009 Influenza A (H1N1)  O Influenza virus co-infection (specify)</td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
</tr>
<tr>
<td>□ Viral culture</td>
<td>O Influenza A (Subtyping Not Done)  O Influenza B  O Negative  O Influenza A (Unable To Subtype)  O Influenza A (H1) O Influenza A (H3)  O Influenza virus co-infection (specify)</td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
</tr>
<tr>
<td>□ Fluorescent antibody (IFA or DFA)</td>
<td>O Influenza A (Subtyping Not Done)  O Influenza B  O Negative  O Influenza A (Unable To Subtype)  O Influenza A (H1) O Influenza A (H3)  O Influenza virus co-infection (specify)</td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
</tr>
<tr>
<td>□ Enzyme immunoassay (EIA)</td>
<td>O Influenza A (Subtyping Not Done)  O Influenza B  O Negative  O Influenza A (Unable To Subtype)  O Influenza A (H1) O Influenza A (H3)  O Influenza virus co-infection (specify)</td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
</tr>
<tr>
<td>□ RT-PCR</td>
<td>O Influenza A (Subtyping Not Done)  O Influenza B  O Negative  O Influenza A (Unable To Subtype)  O Influenza A (H1) O Influenza A (H3)  O Influenza virus co-infection (specify)</td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
</tr>
<tr>
<td>□ Immunohistochemistry (IHC)</td>
<td>O Influenza A  O Influenza B  O Negative  O Influenza virus co-infection (specify)</td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
</tr>
</tbody>
</table>

Culture confirmation of bacterial pathogens from STERILE (Invasive) SITES

16 a. Was a specimen collected for bacterial culture from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid)  O Yes  O No  O Unknown

16 b. 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.*

<table>
<thead>
<tr>
<th>Specimen Type</th>
<th>Collection Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Blood</td>
<td>Date <strong>/</strong>/_____</td>
<td>O Positive O Negative O Unknown</td>
</tr>
<tr>
<td>□ Pleural fluid</td>
<td>Date <strong>/</strong>/_____</td>
<td>O Positive O Negative O Unknown</td>
</tr>
<tr>
<td>□ CSF</td>
<td>Date <strong>/</strong>/_____</td>
<td>O Positive O Negative O Unknown</td>
</tr>
<tr>
<td>□ Other _______________</td>
<td>Date <strong>/</strong>/_____</td>
<td>O Positive O Negative O Unknown</td>
</tr>
<tr>
<td>□ Unknown</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- □ *Streptococcus pneumoniae*
- □ *Staphylococcus aureus, methicillin sensitive (MSSA)*
- □ *Haemophilus influenzae not-type b*
- □ *Group A streptococcus*
- □ *Staphylococcus aureus, methicillin resistant (MRSA)*
- □ *Haemophilus influenzae type b*
- □ *Other bacteria: (If reporting another viral co-infection please do so in section 19 Clinical Diagnosis and Complications)*
- □ *Staphylococcus aureus, sensitivity not done*
- □ *Pseudomonas aeruginosa*
16 d. Were other respiratory specimens collected for bacterial culture (e.g., sputum, ET tube aspirate)?

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.

<table>
<thead>
<tr>
<th>Specimen Type</th>
<th>Collection Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sputum</td>
<td>Date / /</td>
<td>O Positive O Negative O Unknown</td>
</tr>
<tr>
<td>ET tube</td>
<td>Date / /</td>
<td>O Positive O Negative O Unknown</td>
</tr>
<tr>
<td>Other</td>
<td>Date / /</td>
<td>O Positive O Negative O Unknown</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- Streptococcus pneumoniae
- Staphylococcus aureus, methicillin sensitive (MSSA)
- Haemophilus influenzae not-type b
- Group A streptococcus
- Staphylococcus aureus, methicillin resistant (MRSA)
- Haemophilus influenzae type b
- Other bacteria: Staphylococcus aureus, sensitivity not done
- Pseudomonas aeruginosa

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”)

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

17. Was the patient placed on mechanical ventilation?
### 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
- [ ] Sepsis
- [ ] Hemorrhagic pneumonia/pneumonitis
- [ ] Cardiomyopathy/myocarditis
- [ ] 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/congenital heart disease (specify) ___________
- [ ] Renal disease (specify) ____________
- [ ] Skin or soft tissue infection (SSTI)
- [ ] Chromosomal Abnormality/Genetic Syndrome (specify) ____________
- [ ] Mitochondrial Disorder (specify) ____________
- [ ] Chronic pulmonary disease (specify) ____________
- [ ] Immunosuppressive condition (specify) ____________
- [ ] Cancer (diagnosis and/or treatment began in previous 12 months) (specify) ____________
- [ ] Endocrine disorder (specify) ____________
- [ ] Obesity
- [ ] Cerebral Palsy
- [ ] Prematurity (specify gestational age) __ weeks
- [ ] Neuromuscular disorder (e.g. muscular dystrophy) (specify) ____________
- [ ] Other Neurological disorder (specify) ____________
- [ ] Pregnant (specify gestational age) __ weeks
- [ ] Other (specify) ____________

### Medication and Therapy History

20 a. Was the patient receiving any of the following therapies prior to illness onset?  
(if yes, check all that apply)

- [ ] Yes
- [ ] No
- [ ] Unknown

- [ ] Antiviral Prophylaxis
- [ ] Chronic aspirin therapy
- [ ] Chemotherapy or radiation therapy
- [ ] Steroids by mouth or injection

- [ ] other immunosuppressive therapy: __________________

20 b. Did the patient receive any of the following after illness onset? (if yes, check all that apply)

- [ ] Yes
- [ ] No
- [ ] Unknown

- [ ] Antibiotic therapy specify___________
- [ ] Antiviral therapy specify___________
## Influenza Vaccine History

21. Did the patient receive any **seasonal** influenza vaccine during the current season (before illness)?  
   - O Yes  
   - O No  
   - O Unknown

22. If YES*, please specify the **seasonal** influenza vaccine received before illness onset:  
   - □ Trivalent inactivated influenza vaccine (TIV) [injected]  
   - □ Live-attenuated influenza vaccine (LAIV) [nasal spray]  
   - □ Unknown

23. If YES for seasonal vaccine*, how many doses did the patient receive and what was the timing of each dose? (Enter vaccination dates if available)

<table>
<thead>
<tr>
<th>O 1 dose</th>
<th>Date dose given:</th>
<th>Date of 2nd dose:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONLY</td>
<td>□ &lt;14 days prior to illness onset</td>
<td>□ ≥14 days prior to illness onset</td>
</tr>
<tr>
<td></td>
<td>MM / DD / YYYY</td>
<td>MM / DD / YYYY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>O 2 doses</th>
<th>Date of 1st dose:</th>
<th>Date of 2nd dose:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MM / DD / YYYY</td>
<td>MM / DD / YYYY</td>
</tr>
</tbody>
</table>

24. Did the patient receive any **seasonal** influenza vaccine in previous seasons?  
   - O Yes  
   - O No  
   - O Unknown

24a. If YES to question 24, and patient was between 6 months and ≤ 8 years of age at the time of death, was the 2009-2010 influenza season the first time the patient received **seasonal** influenza vaccine?  
   - O Yes  
   - O No  
   - O Unknown

24b. If YES to question 24a, did the patient receive 2 doses of **seasonal** influenza vaccine during the 2009-2010 influenza season?  
   - O Yes  
   - O No  
   - O Unknown

25. If the patient was between 6 months and ≤ 8 years of age at the time of death, did they receive at least one dose of **2009 influenza A (H1N1)** vaccine during the previous season?  
   - O Yes  
   - O No  
   - O Unknown

Submitted By: ____________________________________________________________  
Date: _______/ _______/ _______  
Phone No.: (            )___-______  
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).