

Influenza-Associated Pediatric Mortality Case Report Form

Form Approved
OMB No. 0920-0004

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: _____ O Days O Months O Years	6. Date of birth: ____/____/____ MM DD YYYY	7a. Is sex known? ☐ Yes ☐ No 7b. Sex: O Male O Female	
8a. Is ethnicity known? ☐ Yes ☐ No 8b. Ethnicity: O Hispanic or Latino O Not Hispanic or Latino			
9a. Is race known? ☐ Yes ☐ No 9b. Race: ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native			

Death Information

10. Date of illness onset: ____/____/____ MM DD YYYY	11. Date of death: ____/____/____ MM DD YYYY	12. Was an autopsy performed? O Yes O No O Unknown
13 a. Did cardiac/respiratory arrest occur outside the hospital? O Yes O No O Unknown		
13 b. Location of death: O Outside the Hospital (e.g. home or in transit to hospital) O Emergency Dept (ED) O Inpatient ward O ICU O 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 _____	O Yes O No O Unknown
14 b. Were influenza isolates or original clinical material sent to CDC's Influenza Division? Please provide the lab ID No. if known _____	O Yes O No O Unknown

Public reporting burden of this collection of information is estimated to average 30 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0004).

Influenza Testing (check all that were used)		
Test Type	Result	Specimen Collection Date
15. ☐ Commercial rapid diagnostic test	☐ Influenza A ☐ Influenza B ☐ Negative ☐ Influenza A/B (Not Distinguished) ☐ Influenza A (H1N1)pdm09 ☐ Influenza virus co-infection (specify) _____	____/____/____
☐ Viral culture	☐ Influenza A (Subtyping Not Done) ☐ Influenza A (H1N1)pdm09 ☐ Influenza A (H3) ☐ Influenza A (H3N2v) ☐ Influenza A (Unable To Subtype) ☐ Influenza B (Lineage Not Determined) ☐ Influenza B/Victoria lineage ☐ Influenza B/Yamagata lineage ☐ Influenza virus co-infection (specify) _____ ☐ Negative	____/____/____
☐ Fluorescent antibody (IFA or DFA)	☐ Influenza A (Subtyping Not Done) ☐ Influenza B ☐ Negative ☐ Influenza A (Unable To Subtype) ☐ Influenza A (H3) ☐ Influenza A (H1N1)pdm09 ☐ Influenza virus co-infection (specify) _____	____/____/____
☐ Enzyme immunoassay (EIA)	☐ Influenza A (Subtyping Not Done) ☐ Influenza B ☐ Negative ☐ Influenza A (Unable To Subtype) ☐ Influenza A (H3) ☐ Influenza A (H1N1)pdm09 ☐ Influenza virus co-infection (specify) _____	____/____/____
☐ RT-PCR	☐ Influenza A (Subtyping Not Done) ☐ Influenza A (H1N1)pdm09 ☐ Influenza A (H3) ☐ Influenza A (H1) (prior to 2010) ☐ Influenza A (H3N2v) ☐ Influenza A (Unable To Subtype) ☐ Influenza B (Lineage Not Determined) ☐ Influenza B/Victoria lineage ☐ Influenza B/Yamagata lineage ☐ Influenza virus co-infection (specify) _____ ☐ Negative	____/____/____
☐ Immunohistochemistry (IHC)	☐ Influenza A ☐ Influenza B ☐ Negative ☐ Influenza virus co-infection (specify) _____	____/____/____

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)? Specimens collected greater than 24 hours after death are not sterile. ☐ Yes ☐ No ☐ Unknown																							
16 b. If yes, please indicate the site from which the specimen was obtained and the result. <i>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.</i> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Specimen Type</th> <th style="text-align: left;">Collection Date</th> <th style="text-align: left;">Result</th> </tr> </thead> <tbody> <tr> <td>☐ Blood</td> <td>Date ____/____/____</td> <td>☐ Positive ☐ Negative ☐ Unknown</td> </tr> <tr> <td>☐ Pleural fluid</td> <td>Date ____/____/____</td> <td>☐ Positive ☐ Negative ☐ Unknown</td> </tr> <tr> <td>☐ CSF</td> <td>Date ____/____/____</td> <td>☐ Positive ☐ Negative ☐ Unknown</td> </tr> <tr> <td>☐ Lung Tissue</td> <td>Date ____/____/____</td> <td>☐ Positive ☐ Negative ☐ Unknown</td> </tr> <tr> <td>☐ Other _____</td> <td>Date ____/____/____</td> <td>☐ Positive ☐ Negative ☐ Unknown</td> </tr> <tr> <td>☐ Unknown</td> <td></td> <td></td> </tr> </tbody> </table>			Specimen Type	Collection Date	Result	☐ Blood	Date ____/____/____	☐ Positive ☐ Negative ☐ Unknown	☐ Pleural fluid	Date ____/____/____	☐ Positive ☐ Negative ☐ Unknown	☐ CSF	Date ____/____/____	☐ Positive ☐ Negative ☐ Unknown	☐ Lung Tissue	Date ____/____/____	☐ Positive ☐ Negative ☐ Unknown	☐ Other _____	Date ____/____/____	☐ Positive ☐ Negative ☐ Unknown	☐ Unknown		
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16 c. If positive, please check the organism cultured. ☐ <i>Streptococcus pneumoniae</i> ☐ <i>Staphylococcus aureus</i>, methicillin sensitive (MSSA) ☐ <i>Haemophilus influenzae</i> not-type b ☐ Group A <i>Streptococcus</i> ☐ <i>Staphylococcus aureus</i>, methicillin resistant (MRSA) ☐ <i>Haemophilus influenzae</i> type b ☐ Other bacteria: _____ <i>(If reporting another viral co-infection please do so in section 18 Clinical Diagnosis and Complications)</i> ☐ <i>Staphylococcus aureus</i>, sensitivity not done ☐ <i>Pseudomonas aeruginosa</i>																							

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

☐ Sputum

Date / /

O Positive O Negative O Unknown

☐ ET tube

Date / /

O Positive O Negative O Unknown

☐ Other

Date / /

O Positive O Negative O Unknown

☐ Unknown

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*

(If reporting another viral co-infection please do so in section 18 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. Was the patient placed on mechanical ventilation?

O Yes

O No

O Unknown

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 |
| ☐ Cardiac disease/congenital heart disease (specify) _____ | ☐ Renal disease (specify) _____ | ☐ Cystic fibrosis |
| ☐ Chromosomal Abnormality/Genetic Syndrome (specify) _____ | ☐ Mitochondrial Disorder (specify) _____ | ☐ Skin or soft tissue infection (SSTI) |
| ☐ Chronic pulmonary disease (specify) _____ | ☐ Immunosuppressive condition (specify) _____ | |
| ☐ Cancer (diagnosis and/or treatment began in previous 12 months) (specify) _____ | ☐ Endocrine disorder (specify) _____ | ☐ Obesity |
| ☐ Neuromuscular disorder (e.g. muscular dystrophy) (specify) _____ | ☐ Other Neurological disorder (specify) _____ | ☐ Cerebral Palsy |
| ☐ Pregnant (specify gestational age) _____ weeks | ☐ Other (specify) _____ | ☐ Premature at birth (specify gestational age) _____ weeks |

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 |
| ☐ Other immunosuppressive therapy: _____ | | ☐ Steroids by mouth or injection |

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 influenza vaccine during the current season (before illness)		O Yes O No O Unknown	
22. If YES* , please specify the influenza vaccine received before illness onset:		☐ Inactivated influenza vaccine (IIV3) <i>[injected]</i> ☐ Quadrivalent inactivated influenza vaccine (IIV4) <i>[injected]</i> ☐ Live-attenuated influenza vaccine (LAIV4) <i>[nasal spray]</i> ☐ Unknown	
23. If YES* , how many doses did the patient receive and what was the timing of each dose? (Enter vaccination dates if available)			
O 1 dose ONLY	☐ <14 days prior to illness onset ☐ ≥14 days prior to illness onset	Date dose given: ____/____/____ MM DD YYYY	
O 2 doses	☐ 2 nd dose given <14 days prior to onset ☐ 2 nd dose given ≥14 days prior to onset	Date of 1 st dose: ____/____/____ MM DD YYYY	Date of 2 nd dose: ____/____/____ MM DD YYYY
23b. IF the patient received two doses of influenza vaccine during the current season, please specify the SECOND influenza vaccine received before illness onset:		☐ Inactivated influenza vaccine (IIV3) <i>[injected]</i> ☐ Quadrivalent inactivated influenza vaccine (IIV4) <i>[injected]</i> ☐ Live-attenuated influenza vaccine (LAIV4) <i>[nasal spray]</i> ☐ Unknown	
24. Did the patient receive any influenza vaccine in previous seasons?		O Yes O No O Unknown	
24 a. If YES, and the patient was ≤ 8 years of age at time of death, have they received a total of 2 or more doses of influenza vaccine (does need not have been received in the same season or consecutive seasons)?		O Yes O No O Unknown	
25a. Were immunization records or information about influenza vaccination available for this case?		O Yes O No O Unknown	
25b. If yes, please check all sources of information on the patient's influenza vaccination history that were reviewed (please check all that apply).			
☐ Patient's immunization record ☐ Immunization information system (registry) ☐ Other (specify): _____		☐ Medical records ☐ Parent report ☐ Coroner's report ☐ News/media report	
Submitted By: _____ Date: ____/____/____ MM DD YYYY Phone No.: (____) _____ E-mail Address: _____			
Case Investigation Closed: ☐ Yes ☐ No			