



# Influenza-Associated Mortality Case Report Form

SC Department of Health & Environmental Control/  
Bureau of Communicable Disease Prevention and Control  
Send to the Regional Health Department

A laboratory confirmed influenza-associated death is defined as a death resulting directly or indirectly from a clinically compatible illness that was confirmed to be influenza by an appropriate laboratory or rapid diagnostic test or autopsy report. There should be no period of complete recovery between the illness and death.

Patient Demographics		
1. Name (Last, First, MI or Middle): _____	2. Address _____	3. City, State, Zip _____
4. County _____ 5. Age: _____ <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Years	6. Date of birth: ____/____/____ MM DD YYYY	7a. Is sex known? <input type="checkbox"/> Yes <input type="checkbox"/> No 7b. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
8a. Is ethnicity known? <input type="checkbox"/> Yes <input type="checkbox"/> No		
8b. Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		
9a. Is race known? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9b. 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		

Death Information		
10. Date of illness onset: ____/____/____ MM DD YYYY	11. Date of death: ____/____/____ MM DD YYYY	12. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
13 a. Did cardiac/respiratory arrest occur outside the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
13 b. Location of death: <input type="checkbox"/> Outside the Hospital (e.g. home or in transit to hospital) <input type="checkbox"/> Emergency Dept (ED) <input type="checkbox"/> Inpatient ward <input type="checkbox"/> ICU <input type="checkbox"/> 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?  Yes  No  Unk  
Please provide the lab ID No. if known\_\_\_\_\_

14 b. Were influenza isolates or original clinical material sent to CDC's Influenza Division?  Yes  No  Unk  
Please provide the lab ID No. if known\_\_\_\_\_

## Influenza Testing (check all that were used)

Test Type	Result	Specimen Collection Date
15. <input type="checkbox"/> Commercial rapid diagnostic test	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A/B (Not Distinguished) <input type="checkbox"/> Influenza A (H1N1)pdm09 <input type="checkbox"/> Influenza virus co-infection (specify)_____	___/___/___
<input type="checkbox"/> Viral culture	<input type="checkbox"/> Influenza A (Subtyping Not Done) <input type="checkbox"/> Influenza A (H1N1)pdm09 <input type="checkbox"/> Influenza A (H3) <input type="checkbox"/> Influenza A (H3N2v) <input type="checkbox"/> Influenza A (Unable To Subtype) <input type="checkbox"/> Influenza B (Lineage Not Determined) <input type="checkbox"/> Influenza B/Victoria lineage <input type="checkbox"/> Influenza B/Yamagata lineage <input type="checkbox"/> Influenza virus co-infection (specify)_____	___/___/___
<input type="checkbox"/> Fluorescent antibody (IFA or DFA)	<input type="checkbox"/> Influenza A (Subtyping Not Done) <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A (Unable To Subtype) <input type="checkbox"/> Influenza A (H3) <input type="checkbox"/> Influenza A (H1N1)pdm09 <input type="checkbox"/> Influenza virus co-infection (specify)_____	___/___/___
<input type="checkbox"/> Enzyme immunoassay (EIA)	<input type="checkbox"/> Influenza A (Subtyping Not Done) <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A (Unable To Subtype) <input type="checkbox"/> Influenza A (H3) <input type="checkbox"/> Influenza A (H1N1)pdm09 <input type="checkbox"/> Influenza virus co-infection (specify)_____	___/___/___
<input type="checkbox"/> RT-PCR	<input type="checkbox"/> Influenza A (Subtyping Not Done) <input type="checkbox"/> Influenza A (H1N1)pdm09 <input type="checkbox"/> Influenza A (H3) <input type="checkbox"/> Influenza A (H1) (prior to 2010) <input type="checkbox"/> Influenza A (H3N2v) <input type="checkbox"/> Influenza A (Unable To Subtype) <input type="checkbox"/> Influenza B (Lineage Not Determined) <input type="checkbox"/> Influenza B/Victoria lineage <input type="checkbox"/> Influenza B/Yamagata lineage <input type="checkbox"/> Influenza virus co-infection (specify)_____ <input type="checkbox"/> Negative	___/___/___
<input type="checkbox"/> Immunohistochemistry (IHC)	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> 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  Unk

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.*

<u>Specimen Type</u>	<u>Collection Date</u>	<u>Result</u>
<input type="checkbox"/> Blood	Date __/__/__	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk
<input type="checkbox"/> Pleural fluid	Date __/__/__	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk
<input type="checkbox"/> CSF	Date __/__/__	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk
<input type="checkbox"/> Lung Tissue	Date __/__/__	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk
<input type="checkbox"/> Other _____	Date __/__/__	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk
<input type="checkbox"/> Unk		

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

<input type="checkbox"/> <i>Streptococcus pneumoniae</i>	<input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin sensitive (MSSA)	<input type="checkbox"/> <i>Haemophilus influenzae</i> not-type b
<input type="checkbox"/> Group A <i>Streptococcus</i>	<input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin resistant (MRSA)	<input type="checkbox"/> <i>Haemophilus influenzae</i> type b
<input type="checkbox"/> Other bacteria: _____ (If reporting another viral co-infection please do so in section 18 Clinical Diagnosis and Complications)	<input type="checkbox"/> <i>Staphylococcus aureus</i> , sensitivity not done	<input type="checkbox"/> <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)?  Yes  No  Unk

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.*

<u>Specimen Type</u>	<u>Collection Date</u>	<u>Result</u>
<input type="checkbox"/> Sputum	Date __/__/__	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk
<input type="checkbox"/> ET tube	Date __/__/__	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk
<input type="checkbox"/> Other _____	Date __/__/__	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk
<input type="checkbox"/> Unk		

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

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

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

(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")  Yes  No  Unk

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?  Yes  No  Unk

### Clinical Diagnoses and Complications

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

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

- |  |  |   |                                   |
|--|--|---|-----------------------------------|
| <input type="checkbox"/> Pneumonia (Chest X-Ray confirmed) | <input type="checkbox"/> Acute Respiratory Disease Syndrome (ARDS) | <input type="checkbox"/> Croup                      | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bronchiolitis                     | <input type="checkbox"/> Encephalopathy/encephalitis               | <input type="checkbox"/> Reye syndrome              | <input type="checkbox"/> Shock    |
| <input type="checkbox"/> Sepsis                            | <input type="checkbox"/> Hemorrhagic pneumonia/pneumonitis         | <input type="checkbox"/> Cardiomyopathy/myocarditis |                                   |
| <input type="checkbox"/> Another viral co-infection: _____ | <input type="checkbox"/> Other: _____                              |   |                                   |

## Clinical Diagnoses and Complications

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

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Moderate to severe developmental delay  | <input type="checkbox"/> Hemoglobinopathy (e.g. sickle cell disease) | <input type="checkbox"/> Asthma/ reactive airway disease                          |
| <input type="checkbox"/> Diabetes mellitus   | <input type="checkbox"/> History of febrile seizures                 | <input type="checkbox"/> Seizure disorder   |
| <input type="checkbox"/> Cardiac disease/congenital heart disease (specify) _____                        | <input type="checkbox"/> Renal disease (specify) _____               | <input type="checkbox"/> Cystic fibrosis  |
| <input type="checkbox"/> Chromosomal Abnormality/Genetic Syndrome (specify) _____                        | <input type="checkbox"/> Mitochondrial Disorder (specify) _____      | <input type="checkbox"/> Skin or soft tissue infection (SSTI)                     |
| <input type="checkbox"/> Chronic pulmonary disease (specify) _____                                       | <input type="checkbox"/> Immunosuppressive condition (specify) _____ |   |
| <input type="checkbox"/> Cancer (diagnosis and/or treatment began in previous 12 months) (specify) _____ | <input type="checkbox"/> Endocrine disorder (specify) _____          | <input type="checkbox"/> Obesity  |
| <input type="checkbox"/> Neuromuscular disorder (e.g. muscular dystrophy) (specify) _____                | <input type="checkbox"/> Other Neurological disorder (specify) _____ | <input type="checkbox"/> Cerebral Palsy   |
| <input type="checkbox"/> Pregnant (specify gestational age) _____ weeks                                  | <input type="checkbox"/> Other (specify) _____                       | <input type="checkbox"/> 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  Unk
- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Antiviral Prophylaxis                  | <input type="checkbox"/> Chronic aspirin therapy | <input type="checkbox"/> Chemotherapy or radiation therapy | <input type="checkbox"/> Steroids by mouth or injection |
| <input type="checkbox"/> Other immunosuppressive therapy: _____ |  |  |   |

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

- Yes  No  Unk
- |   |  |
|---|--|
| <input type="checkbox"/> Antibiotic therapy specify _____ | <input type="checkbox"/> Antiviral therapy specify _____ |
|---|--|

