This form should be faxed to: (951) 358-5102

SEVERE INFLUENZA CASE HISTORY FORM
(ICU AND FATAL CASES AGE 0-64 YEARS)

CASE STATUS (check all that apply)

☐ ICU **A case with laboratory-confirmed influenza requiring admission to an intensive care unit (ICU)**
☐ Fatal **A case with laboratory-confirmed influenza that has died at any location (e.g. hospital, emergency, home)**

PATIENT INFORMATION

Last name	*First name*	*Date of birth*

Street address	*City*	*Zip code*	*Local health jurisdiction of residence*

Gender	*Ethnicity*	*Race*
☐ Female ☐ Male	☐ Hispanic ☐ Non-Hispanic ☐ Unknown	☐ White ☐ Black ☐ Native American ☐ Asian/Pacific Islander ☐ Other ☐ Unknown

ONSET, VACCINATION HISTORY, HOSPITALIZATION AND DEATH INFORMATION

Date of onset of symptoms	*Received this season's influenza vaccine?* ☐ Yes ☐ No ☐ Unknown	*Date received: Dose 1*	Dose 2

If hospitalized, hospital name and location	*Date of hospital admission*	*Date of hospital discharge*

If died, date of death	*If died, location of death (i.e. home, ED-name of hospital ED, etc.)*	*If died, autopsy performed?* ☐ Yes ☐ No ☐ Unknown

INFLUENZA LABORATORY TESTING INFORMATION (Please attach a copy of the test result, if available)

Date of specimen collection	*Specimen type (e.g. nasopharyngeal swabs, endotracheal aspirate, bronchoalveolar lavage)*

Influenza type and/or subtype
Influenza A: ☐(H3) ☐(2009H1N1) ☐(A Unknown – PCR) ☐(A Unknown – rapid test, culture or DFA) ☐ (A – PCR unsubtypable (i.e. novel))
Influenza B: ☐(Yamagata) ☐(Victoria) ☐(B Unknown)

Where was testing performed?

REPORTING AGENCY INFORMATION

Reporting local health jurisdiction	*Name of reporter*	*Telephone number of reporter*

CLINICAL COURSE

Received antiviral treatment? ☐ Yes ☐ No ☐ Unknown	*Type of antiviral* ☐ Oseltamivir ☐ Zanamivir ☐ Other *Specify other*: _____

Date antiviral treatment started	*Date antiviral treatment ended*	*Intubated?* ☐ Yes ☐ No ☐ Unknown

Complications
☐ Pneumonia ☐ ARDS ☐ Sepsis ☐ Acute renal failure ☐ Encephalitis/encephalopathy ☐ Required vasopressor ☐ Required hemodialysis
☐ Pulmonary embolus ☐ Secondary bacterial infection *If yes, specify organism*: _____
☐ Other *Specify other*: _____

SIGNIFICANT PAST MEDICAL HISTORY

Did the patient have underlying medical conditions? ☐ Yes ☐ No ☐ Unknown
☐ Cardiac disease ☐ Chronic pulmonary disorder ☐ Immunosuppression (e.g. cancer) ☐ Immunosuppressive medications (e.g. chemotherapy, steroids)
☐ Metabolic disorder (e.g. diabetes mellitus, renal) ☐ Neurological disorder (e.g. cerebral palsy) ☐ Hemoglobinopathy (e.g. sickle cell disease)
☐ Genetic disorder (e.g. Downs) ☐ Obesity *If obese*, BMI (if known): _____ Height: _____ Weight: _____
☐ Pregnant *If pregnant*, estimated delivery date: _____
☐ Postpartum *If postpartum*, delivery date: _____ ☐ Other conditions (e.g. hypertension, hyperlipidemia)
If yes for any of the above, please specify:

NOTES SECTION (Please attach relevant medical records if available)

The information requested on this form is required by the California Department of Public Health for purposes of identification and public health investigation.

TO REPORT A CASE, PLEASE CONTACT COUNTY OF RIVERSIDE DISEASE CONTROL AT (951) 358-5107 AND FAX THIS FORM TO: (951) 358-5102.
Please forward any available medical records (e.g. H&P, mirco reports, discharge summary, autopsy report) to Disease Control ASAP.