State of California - Health and Human Services Agency

California Department of Public Health

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 ☐ Female ☐ Male

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Unknown ☐ Other: _____

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 – unsubtypable (i.e. novel))

Influenza B: ☐(Yamagata) ☐(Victoria) ☐(B Unknown – PCR) ☐(B Unknown – rapid test, culture or DFA)

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)

CDPH 9070 (updated 08/17)

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.