WEDSS ID _____

(NOVEL) 2009 INFLUENZA A (H1N1) VIRUS HOSPITALIZATIONS OR DEATHS CASE REPORT

Use this form to report hospitalizations or deaths in persons with confirmed or probable (novel) 2009 influenza A (H1N1) virus infection.

Please fax completed form to the local health department or to the Wisconsin Division of Public Health at FAX: 608-261-4976 or FAX: 608-266-2906, or enter information into WEDSS.

PATIENT DEMOGRAPHIC INFORMATION

Last Name | **First Name** | **Middle Initial**

Date of Birth (Month/Day/Year) **Age** ☐ Years ☐ Months ☐ Days

/ /

Residential Address

City | **State** | **Zip Code**

Area Code & Telephone Number ( )

Employer/School

Sex: ☐ Male ☐ Female

If female, Pregnant? ☐ Yes ☐ No ☐ Unknown

If pregnant, estimated delivery date _____/_____/_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐Unknown

Race: ☐ White ☐ Asian ☐ Native American ☐ Native Hawaiian/Pacific Island ☐ Black ☐ Multiracial ☐ Unknown ☐ Other_____

HOSPITAL INFORMATION, ONSET, DEATH

Patient medical record number:

Hospital Name

City | **State** | **Zip Code**

Person completing this form | **Telephone Number** ( )

Date of hospital admission _____/_____/_____ Date of discharge from hospital _____/_____/_____

Date of symptom onset (fever or respiratory symptoms) _____/_____/_____

Patient died of this illness ☐ Yes ☐ No If Yes, Date of death _____/_____/_____

LABORATORY RESULTS

Date first influenza-positive specimen was collected. _____/_____/_____

Laboratory where test was performed _____

Result (check if positive) ☐ (Novel) 2009 influenza A (H1N1)
☐ Unsubtypeable influenza A (not human H1 or H3)
☐ Influenza A, subtyping not performed (Please do not include Rapid Antigen test results)

Were bacterial cultures performed during the first five days of hospitalization?: ☐ Yes ☐ No ☐ Unknown

If any positive, please fill out table below.

Site (blood, CSF, etc)	Date collected	Organism

WEDSS ID _____

CLINICAL INFORMATION

Date of first outpatient visit for this illness _____/_____/_____

Date of first ER visit for this illness _____/_____/_____

Hospitalized for < 24 hours? ☐ Yes ☐ No ☐ Unknown

Transferred from another hospital? ☐ Yes ☐ No ☐ Unknown

Name of hospital _____

If transferred from another hospital, date of first hospital admission _____/_____/_____

Presenting clinical signs and symptoms

- ☐ Fever
- ☐ Chills
- ☐ Fatigue/weakness
- ☐ Headache
- ☐ Runny nose (rhinorrhea)
- ☐ Nasal congestion
- ☐ Sore throat
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Myalgias (muscle aches)
- ☐ Other symptoms:

ILLNESS SEVERITY (During the course of the illness and hospitalization, did the patient require or have any of the following)

Chest X-ray or chest CT during first 5 days in hospital? ☐ Yes ☐ No ☐ Unknown

If Yes, please check findings: ☐ Normal ☐ Infiltrates ☐ Opacities ☐ Consolidation ☐ Pleural effusion

ICU admission? (date) ____/____/____ Date transferred out of ICU: ____/____/____

Mechanical ventilation? ☐ Yes ☐ No ☐ Unknown

Vasopressor or inotropic medications to maintain blood pressure? ☐ Yes ☐ No ☐ Unknown

Acute respiratory distress syndrome (ARDS)? ☐ Yes ☐ No ☐ Unknown

Acute renal failure requiring dialysis? (not end-stage renal disease) ☐ Yes ☐ No ☐ Unknown

MEDICATIONS

Did patient receive antivirals to treat or prevent influenza, either before or during hospitalization? ☐ Yes ☐ No ☐ Unknown

If yes, circle name and indicate date initiated if known.

☐ Oseltamivir (Tamiflu) Date initiated ____/____/____ ☐ Amantadine (Symmetel) Date initiated ____/____/____

☐ Zanamivir (Relenza) Date initiated ____/____/____ ☐ Rimantidine (Flumadine) Date initiated ____/____/____

Did patient receive antibacterial medications during the first five days of hospitalization? ☐ Yes ☐ No ☐ Unknown

If yes, date initiated: _____ / _____ / _____

MEDICAL HISTORY

☐ Obesity *BMI if available* _____ OR Height _____ *cm / inches* Weight _____ *lbs / kg*

☐ Smoking *(current or history of) please specify* _____

WEDSS ID ☐

Check all that apply and specify where indicated ☐ No underlying conditions

☐ Asthma

☐ COPD

☐ Other chronic lung disease _____

☐ Diabetes Mellitus *Please specify type* ☐ Type I ☐ Type II

☐ Chronic Cardiovascular disease (excluding HTN) *please specify* _____

☐ Kidney disease *please specify* _____

☐ Neurologic/Neuromuscular condition (incl. seizure disorder, developmental delay)

*please specify*_____

☐ Hemoglobinopathy (e.g., sickle cell disease) *please specify* _____

☐ Patient < 2 years of age, born premature Gestational age at birth, in weeks _____

☐ Current Immunosuppressive condition (e.g., HIV, chemotherapy, transplant, corticosteroids)

please specify _____

☐ Other chronic disease(s) *please specify* _____

VACCINATION HISTORY

Check if patient has received influenza vaccine since July 2008 and at least 2 weeks prior to hospitalization.

If Yes, specify: ☐ Seasonal influenza vaccine Date (can approximate) _____/_____/_____

☐ 2009 (novel) H1N1 vaccine Date (can approximate) _____/_____/_____

Did the patient ever receive pneumococcal vaccine? ☐ Yes ☐ No ☐ Unknown

Comments:

Signature of Person completing this report

Date Signed