2009-2010-INFLUENZA REPORT FORM
SPECIAL CASES : HOSPITALIZED*/FATAL/PREGNANT

Philadelphia Department of Public Health
Division of Disease Control
Acute Communicable Disease Program
500 South Broad St, Philadelphia, 19146
Telephone (215) 685-6748 Fax (215) 545-8362
Form Available at http:// www.hip.phila.gov

Use this form to report suspected and confirmed cases of influenza who are either hospitalized*, fatal, or pregnant. All other cases do not need to be reported by name, unless indicative of a new outbreak in a facility or institution requiring special containment measures.

DEMOGRAPHIC INFORMATION

REPORTED DATE	PATIENT LAST NAME	FIRST NAME	D.O.B	AGE (y)	SEX	RACE
			___/___/_____		☐F ☐M	

STREET ADDRESS	CITY	ZIP CODE

TELEPHONE # Home	Work or Mobile	OCCUPATION (OR SCHOOL)	PARENT or CARETAKER NAME

CLINICAL INFORMATION

SYMPTOMS Onset Date: _____/_____/_____ ☐ Cough ☐ Shortness of breath ☐ Diarrhea
☐ Fever Highest temp(F) _____ ☐ Muscle Aches ☐ Headaches ☐ Other, Specify: _____

VITAL SIGNS Height _____ (ft, in) Weight _____ lb or _____kg OR BMI _____

UNDERLYING CONDITIONS (Check those that apply)

☐ None ☐ Chronic Heart Disease/Cardiovascular Disease ☐ Kidney Disease
☐ Unknown ☐ COPD ☐ Pregnant Gestation Weeks:_____
☐ Asthma ☐ Diabetes ☐ Smokes Tobacco
☐ Cancer in the past year ☐ Immunosuppression, Specify : _____ ☐ Other, Specify: _____

VACCINATION STATUS (Y=Yes; N=No; DK=Don't Know)

Y	N	DK			
☐	☐	☐	Received Flu Vaccine?	☐ Seasonal Date: ____/___/___	☐ H1N1 Date 1: ____/___/___ Date 2: ____/___/____

LABORATORY (Check all tests that were POSITIVE for influenza)

☐ Rapid Antigen Test → Specify flu type: ☐ A ☐ B ☐ A/B
☐ Influenza A, Culture
☐ Influenza A DFA ☐ Influenza B, Test type:_____
☐ Influenza A PCR ☐ Influenza, Other:_____

Specimen Collection Date: ____/___/___
Laboratory:_____
If sent to State Lab -- BOLID#: _____

TREATMENT Was antiviral treatment prescribed? ☐Y ☐ N ☐DK **Antiviral Drug** ☐ Tamiflu ☐ Relenza ☐ Other _____

HOSPITALIZED */ FATAL CASE (if applicable)

HOSPITALIZED* / FATAL CASE

Y	N	DK		
☐	☐	☐	Hospitalized*?	
☐	☐	☐	Fatal? **Date of Death:** ___/___/___ Autopsy **Y**☐ **N**☐ **DK**☐	

Hospital Name

Admit Date	Dischg. Date	Medical Rec#	Physician Name	Physician Phone Number/Pager #
____/____/____	___/___/___			

Medical Complications ☐ NONE ☐ Pneumonia (X-ray confirmed) ☐ Acute Respiratory Distress Syndrome (ARDS)
☐ Super-infection (specify organism(s)/type of infection(s):_____ ☐ Bacteremia (specify organism(s):_____)
☐ Other, specify:_____

Hospital Critical Care Information ☐ Admission to ICU If ventilatory support , specify: ☐ Mechanical ventilation ☐ ECMO

REPORTER INFORMATION

REPORTER NAME	FACILITY NAME:	REPORTER PHONE #:	TYPE: ☐ DO/MD ☐ ICP ☐ PA ☐ RN ☐ Other_____

* Hospitalized defined as patient spent ≥ 24 hours in hospital NOT in Emergency Department