

**INFLUENZA REPORT FORM  
SPECIAL CASES : PREGNANT OR  
HOSPITALIZED / FATAL CASES**



**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**

Use this form to report suspected and confirmed cases of influenza who are either hospitalized 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.

REPORTED DATE	PATIENT LAST NAME	FIRST NAME	D.O.B _/_/___	AGE (y)	SEX <input type="checkbox"/> F <input type="checkbox"/> M	RACE
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STREET ADDRESS	CITY	ZIP CODE
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TELEPHONE # Home	Work or Mobile	OCCUPATION (OR SCHOOL)	PARENT or CARETAKER NAME:
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**CLINICAL INFORMATION**

ONSET DATE _/_/___	DIAGNOSING PHYSICIAN	DIAGNOSING PHYSICIAN PHONE #
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SIGNS and SYMPTOMS  Sore throat  Cough  Fever Highest temp(F) \_\_\_\_\_  Other, Specify: \_\_\_\_\_

**UNDERLYING CONDITIONS (Check those that apply):**

Asthma  Chronic Heart Disease/Cardiovascular Disease  Immunosuppression, Specify : \_\_\_\_\_  
 Diabetes  COPD  Other, Specify: \_\_\_\_\_  
 Kidney Disease  Cancer in the past year  Unknown

LABORATORY Check all tests that were positive for influenza Specimen collection date \_\_\_/\_\_\_/\_\_\_  
 Rapid Antigen Test  Influenza A PCR  Influenza A DFA  Culture Influenza A

**TREATMENT**

Was antiviral treatment prescribed?  Y  N  DK Antiviral Drug:  Tamiflu  Relenza  Other \_\_\_\_\_

**PREGNANT (if applicable)**

GESTATION WEEKS:	NAME of OBSTETRICIAN OR PRACTICE :	PHONE #:
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**HOSPITALIZED / FATAL CASE (if applicable)**

<b>HOSPITALIZED / FATAL CASE</b>	Y N DK NA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hospitalized? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatal? Date of Death: _____
	HOSPITAL NAME Admit Date Dischg. Date Medical Rec# _/_/___ _/_/___
	Medical complications? <input type="checkbox"/> NONE <input type="checkbox"/> Pneumonia (X-ray confirmed) <input type="checkbox"/> Acute Respiratory Disease Syndrome (ARDS) <input type="checkbox"/> Super-infection (specify organism/type of infection: _____) <input type="checkbox"/> Bacteremia (specify organism: _____) <input type="checkbox"/> Other, specify: _____
	Patient Status? <input type="checkbox"/> Admit to Regular Floor <input type="checkbox"/> Admission to ICU <input type="checkbox"/> Discharged? Date of discharge ___/___/___
	If ventilatory support , specify: <input type="checkbox"/> Mechanical ventilation <input type="checkbox"/> ECMO

**REPORTER INFORMATION**

REPORTER NAME	FACILITY NAME:	REPORTER PHONE #:	TYPE: <input type="checkbox"/> ICP <input type="checkbox"/> MD <input type="checkbox"/> RN <input type="checkbox"/> Other _____
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