

# 2015 2016 RESPIRATORY VIRUS REPORT FORM

## ICU OR FATAL CASES



**Philadelphia Department of Public Health**  
**Division of Disease Control**  
 Acute Communicable Disease Program  
 500 South Broad St, Philadelphia, 19146  
**Telephone (215) 685-6740 Fax (215) 238-6947**  
**Form Available at [hip.phila.gov](http://hip.phila.gov)**

Use this form to report suspected and confirmed cases of respiratory virus infection that are either admitted to the ICU or fatal. 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.

Please continue to report confirmed cases of influenza by using the Influenza Report Form for Hospitalized or Fatal Cases.

### PATIENT INFORMATION

Report Date _/_/___	Last Name	First Name	D.O.B. _/_/___	Age (D, W, M, Y)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Race/ Ethnicity
Street Address			City		Zip Code	
Phone #	<input type="checkbox"/> Lives in congregate setting Specify Location: _____		<input type="checkbox"/> Attends school/ daycare Specify Location: _____			

### HOSPITALIZATION AND LABORATORY INFORMATION

**HOSPITALIZATION** Y=Yes; N=No; DK=Don't Know

Admission Date: \_/\_/\_\_\_ Discharge Date: \_/\_/\_\_\_

Hospital Name: \_\_\_\_\_ Diagnosing Physician: \_\_\_\_\_ \*Admitted to ICU?  Y  N  DK

Medical Record #: \_\_\_\_\_ Physician Phone #: \_\_\_\_\_ \*Fatal?  Y  N  DK

Date of Death: \_/\_/\_\_\_  
 \*If yes to either question, complete clinical information below.

**LABORATORY** (Check all POSITIVE tests)

Laboratory Name: \_\_\_\_\_

Specimen Collection Date: \_/\_/\_\_\_

Source (if not nasopharynx): \_\_\_\_\_

<input type="checkbox"/> Respiratory Syncytial Virus <input type="checkbox"/> RT-PCR <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> DFA/IFA <input type="checkbox"/> Culture	<input type="checkbox"/> Human Metapneumovirus <input type="checkbox"/> RT-PCR <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> DFA/IFA <input type="checkbox"/> Culture
<input type="checkbox"/> Rhinovirus <input type="checkbox"/> RT-PCR <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> DFA/IFA <input type="checkbox"/> Culture	<input type="checkbox"/> Enterovirus <input type="checkbox"/> RT-PCR <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> DFA/IFA <input type="checkbox"/> Culture
<input type="checkbox"/> Adenovirus <input type="checkbox"/> RT-PCR <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> DFA/IFA <input type="checkbox"/> Culture	<input type="checkbox"/> Other Respiratory Virus Specify Name and Test: _____
<input type="checkbox"/> Parainfluenza <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> RT-PCR <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> DFA/IFA <input type="checkbox"/> Culture	

### ADDITIONAL CLINICAL INFORMATION

**SYMPTOMS**

Onset Date: \_/\_/\_\_\_

<input type="checkbox"/> Fever, Highest temp (F): _____	<input type="checkbox"/> Coryza	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nausea	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Cough	<input type="checkbox"/> Ear Ache	<input type="checkbox"/> Headache	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Conjunctivitis
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Chills	<input type="checkbox"/> Neurologic, Specify: _____	
<input type="checkbox"/> Shortness of Breath/Difficulty Breathing	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Muscle Aches	<input type="checkbox"/> Other, Specify: _____	

### UNDERLYING CONDITIONS

<input type="checkbox"/> None	<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Asthma	<input type="checkbox"/> Smokes Tobacco	<input type="checkbox"/> Postpartum
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Morbidly Obese (BMI >40)
<input type="checkbox"/> Preterm Birth (Gestation <37 weeks)	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Unknown
<input type="checkbox"/> Immunosuppression, Specify: _____	<input type="checkbox"/> Neurological, Specify: _____	<input type="checkbox"/> Other, Specify: _____

### MEDICAL COMPLICATIONS

None  Acute Respiratory Distress Syndrome (ARDS)  Bacteremia  Pneumonia (X-ray confirmed)  Other, Specify: \_\_\_\_\_

### CLINICAL MANAGEMENT

Was Synagis (palivizumab) prophylaxis prescribed? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Was a bronchodilator prescribed? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
Date First Dose Received: _/_/___ Number of Doses: _____	Was antibiotic treatment prescribed? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
Was Virazole (ribavirin) treatment prescribed? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Indication: _____
Was a corticosteroid prescribed? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Was mechanical ventilation used? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK

### REPORTER INFORMATION

Facility Name	Reporter Name	Reporter Phone #	Title: <input type="checkbox"/> ICP <input type="checkbox"/> DO/MD <input type="checkbox"/> PA/NP <input type="checkbox"/> RN <input type="checkbox"/> Other, Specify: _____
---------------	---------------	------------------	---

Please fax report to (215) 238-6947 upon completion. If case is associated with a suspect outbreak, please indicate on form.