

2016-2017 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

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: _____

Medical Record #: _____ Physician Phone #: _____

*Admitted to ICU? Y N DK
 *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 Date First Dose Received: _/_/___ Number of Doses: _____	Was a bronchodilator 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	Was antibiotic 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.