2022–2023 SEVERE RESPIRATORY VIRUS CASE REPORT FORM

Philadelphia Department of Public Health
Division of Disease Control
Acute Communicable Disease Program
1101 Market St 12th Fl, Philadelphia, 19107
Telephone (215) 685-6740 Fax (215) 238-6947
Form Available at hip.phila.gov

Use this form to report the following patients with severe respiratory infections: 1) COVID-19 hospitalizations, ICU admissions, and fatal cases; 2) influenza hospitalizations, ICU admissions, and fatal cases; and 3) other respiratory virus ICU admissions and fatal cases. 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.

PATIENT INFORMATION

Report Date	Last Name	First Name	D.O.B	Age (D, W, M, Y)	Sex ☐ M ☐ F

Street Address	City	Zip Code

Phone Number	Race ☐ African-American ☐ White ☐ Asian ☐ Pacific Islander ☐ Native-American ☐ Unknown ☐ Other: _____	Hispanic or Latino ☐ Yes ☐ No ☐ Unk	Pregnant ☐ Yes ☐ No ☐ Unk

☐ Lives in congregate setting (Nursing home, shelter, behavioral health facility, etc.) Specify location: _____	☐ Works in congregate setting Specify location: _____	☐ Attends daycare/school Specify location: _____

Report Type: ☐COVID-19 Hospitalization, ICU Admission or Death ☐Influenza Hospitalization, ICU Admission or Death ☐ Other Virus ICU Admission or Death

HOSPITALIZATION

Hospital Name _____

Admission Date: _____

Discharge Date: _____

Medical Record # _____

Hospitalized for ≥ 24hrs ☐Yes ☐No ☐Unk

ICU Admission ☐ Yes ☐ No ☐ Unk

Fatal ☐ Yes ☐ No ☐ Unk
Death Date: _____

Mechanical Ventilation ☐ Yes ☐ No ☐ Unk

ECMO ☐ Yes ☐ No ☐ Unk

LABORATORY *(Check all POSITIVE tests)*

Laboratory Name: _____

Specimen Collection Date: _____

Source (if not nasopharynx): _____

☐ SAR-CoV-2
☐RT-PCR ☐Rapid Antigen ☐Rapid Molecular

☐ Respiratory Syncytial Virus
☐RT-PCR ☐Rapid Antigen ☐DFA/IFA ☐Culture

☐ Adenovirus
☐RT-PCR ☐Rapid Antigen ☐DFA/IFA ☐Culture

☐ Human Metapneumovirus
☐RT-PCR ☐Rapid Antigen ☐DFA/IFA ☐Culture

☐ Influenza (Type: ☐Flu A, ☐Flu B, ☐Flu A/B)
☐RT-PCR ☐Rapid Antigen ☐DFA/IFA ☐Culture

☐ Rhinovirus/Enterovirus
☐RT-PCR ☐Rapid Antigen ☐DFA/IFA ☐Culture

☐ Parainfluenza (Type: ☐1, ☐2, ☐3, ☐4)
☐RT-PCR ☐Rapid Antigen ☐DFA/IFA ☐Culture

☐ Other Respiratory Virus (Specify: _____)
☐RT-PCR ☐Rapid Antigen ☐DFA/IFA ☐Culture

ADDITIONAL CLINICAL INFORMATION

SYMPTOMS

Onset Date: _____

☐ Fever, Highest temp (F): _____
☐ Cough
☐ Sore Throat
☐ Shortness of Breath/Difficulty Breathing
☐ Runny Nose
☐ Earache
☐ Sneezing
☐ Wheezing
☐ Fatigue
☐ Headache
☐ Chills
☐ Muscle Aches
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Conjunctivitis
☐ Loss of Sense of Taste or Smell
☐ Other (specify: _____)

MEDICAL COMPLICATIONS

☐ None ☐ Acute Respiratory Distress Syndrome (ARDS) ☐ Bacteremia ☐ Pneumonia (X-ray confirmed) ☐ Pulmonary Embolism ☐ Other (specify: _____)

UNDERLYING CONDITIONS

☐ None ☐ Asthma ☐ Chronic Liver Disease ☐ COPD ☐ Other Chronic Lung Disease ☐ Chronic Renal Disease ☐ Diabetes ☐ Heart Disease ☐ Hypertension

☐ Immunosuppression (specify: _____) ☐ Obesity ☐ Preterm Birth (Gestation <37 weeks) ☐ Former Smoker ☐ Current Smoker ☐Other (specify: _____)

MEDICATIONS

☐ Antiviral (name: _____) ☐ Steroid ☐ Bronchodilator ☐ Antibiotic (Indication: _____) ☐ Other (specify: _____)

VACCINATION AND IMMUNOPROPHYLAXIS

☐ Seasonal Influenza Vaccine (Date: _____) ☐ COVID-19 Bivalent Booster (Date: _____) ☐ Synagis (# of Doses: ___) ☐ Other (specify: _____)

REPORTER INFORMATION

Facility Name	Reporter Name	Reporter Phone #	Title: ☐ IP ☐ DO/MD ☐ PA/NP ☐ RN ☐ Other (specify: _____)

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