2020-2021 INFLUENZA REPORT FORM
HOSPITALIZED OR FATAL CASES

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 suspected and confirmed cases of influenza that are either hospitalized (24 hours or more) 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.

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 ☐Y ☐N ☐DK	Pregnant ☐Y ☐N ☐DK

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

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

Hospital Name: _____

Medical Record #: _____

Admission Date: ___/___/_____ Discharge Date: ___/___/_____

Hospitalized for ≥ 24 hours ☐ Y ☐ N ☐ DK

Diagnosing Physician: _____

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): _____

☐ Rapid Antigen Test,
Specify flu type: ☐ A ☐ B ☐ A/B

☐ Influenza A, Culture

☐ Influenza A, DFA/IFA

☐ Influenza A, PCR

☐ Influenza B, Culture

☐ Influenza B, DFA/IFA

☐ Influenza B, PCR

☐ Other Respiratory Virus,
Specify: _____

FOR ICU OR FATAL CASES ONLY PLEASE COMPLETE ADDITIONAL CLINICAL INFORMATION

SYMPTOMS

Onset Date: ___/___/_____

☐ Fever, Highest temp (F): _____
☐ Cough
☐ Sore Throat
☐ Nasal Congestion
☐ Conjunctivitis
☐ Shortness of Breath
☐ Parotitis
☐ Headaches
☐ Muscle Aches
☐ Chills
☐ Fatigue
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Other, Specify: _____

UNDERLYING CONDITIONS

☐ None
☐ Unknown
☐ Asthma
☐ Cardiovascular Disease
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Diabetes
☐ Immunosuppression, Specify: _____
☐ Kidney Disease
☐ Morbidly Obese (BMI >40)
☐ Neurological, Specify: _____
☐ Current/Former Smoker
☐ Other, Specify: _____

MEDICAL COMPLICATIONS

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

CLINICAL MANAGEMENT

Was antiviral treatment prescribed? ☐ Y ☐ N ☐ DK
Start Date: ___/___/_____ End Date: ___/___/_____
Antiviral Drug: ☐ Oseltamivir (Tamiflu) ☐ Zanamivir (Relenza)
☐ Other, Specify: _____

Was antibiotic treatment prescribed? ☐ Y ☐ N ☐ DK
Indication: _____

Was mechanical ventilation used? ☐ Y ☐ N ☐ DK

VACCINATION HISTORY

Received current seasonal flu vaccine? ☐ Y ☐ N ☐ DK Date Dose Received: ___/___/_____

REPORTER INFORMATION

Facility Name	Reporter Name	Reporter Phone #	Title: ☐ ICP ☐ 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.