

2024–2025 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 <input type="checkbox"/> M <input type="checkbox"/> F
Street Address			City	Zip Code	
Phone Number	Race <input type="checkbox"/> African-American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native-American <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		Hispanic or Latino <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
<input type="checkbox"/> Lives in congregate setting (Nursing home, shelter, behavioral health facility, etc.) Specify location: _____		<input type="checkbox"/> Works in congregate setting Specify location: _____		<input type="checkbox"/> 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: _____	ICU Admission <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Fatal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Discharge Date: _____	Death Date: _____	
Medical Record #	Hospitalized for ≥ 24hrs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Mechanical Ventilation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	ECMO <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Hospitalized for reasons other than respiratory illness <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, other reason: _____		

LABORATORY (Check all POSITIVE tests)	<input type="checkbox"/> SAR-CoV-2 <input type="checkbox"/> RT-PCR <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> Rapid Molecular	<input type="checkbox"/> Influenza (Type: <input type="checkbox"/> Flu A, <input type="checkbox"/> Flu B, <input type="checkbox"/> Flu A/B) <input type="checkbox"/> RT-PCR <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> DFA/IFA <input type="checkbox"/> Culture
	<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"/> Rhinovirus/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"/> Parainfluenza (Type: <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
	<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"/> Other Respiratory Virus (Specify: _____) <input type="checkbox"/> RT-PCR <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> DFA/IFA <input type="checkbox"/> Culture
Laboratory Name: _____	Specimen Collection Date: _____	Source (if not nasopharynx): _____

ADDITIONAL CLINICAL INFORMATION

SYMPTOMS	<input type="checkbox"/> Fever, Highest temp (F): _____	<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nausea	<input type="checkbox"/> Diarrhea
	<input type="checkbox"/> Cough	<input type="checkbox"/> Earache	<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"/> Loss of Sense of Taste or Smell	
	<input type="checkbox"/> Shortness of Breath/Difficulty Breathing	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Muscle Aches	<input type="checkbox"/> Other (specify: _____)	
Onset Date: _____					

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: _____) Fall 2024 COVID-19 Vaccine (Date: _____)
 Beyfortus (Date: _____) Synagis (# of Doses: _____) RSV Vaccine (Date: _____) Other: (Specify: _____)

REPORTER INFORMATION

Facility Name	Reporter Name	Reporter Phone #	Title: <input type="checkbox"/> IP <input type="checkbox"/> DO/MD <input type="checkbox"/> PA/NP <input type="checkbox"/> RN <input type="checkbox"/> Other (specify: _____)
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Please fax report to (215) 238-6947 upon completion. If case is associated with a suspect outbreak, please indicate on form.