2020-2021 Respiratory Virus Report Form ICU 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 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 ☐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 facility, etc) Specify location:	☐ Works in congregate setting Specify location:	☐ Attends daycare/school Specify location:

HOSPITALIZATION

Hospital Name: ____________

Medical Record #: ____________

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

Diagnosing Physician: ____________

Physician Phone #: ____________

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

*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): ____________

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

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

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

☐ Parainfluenza ☐1 ☐2 ☐3 ☐4
☐RT-PCR ☐Rapid Antigen ☐DFA/IFA ☐Culture

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

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

☐ Other Respiratory Virus
Specify Name and Test: ____________

ADDITIONAL CLINICAL INFORMATION

SYMPTOMS

Onset Date: ___/___/_____

☐ Fever, Highest temp (F): ________
☐ Cough
☐ Sore Throat
☐ Shortness of Breath/Difficulty Breathing
☐ Coryza
☐ Ear Ache
☐ Sneezing
☐ Wheezing
☐ Fatigue
☐ Headache
☐ Chills
☐ Muscle Aches
☐ Nausea
☐ Vomiting
☐ Neurologic, Specify: ________
☐ Other, Specify: ________
☐ Diarrhea
☐ Conjunctivitis

UNDERLYING CONDITIONS

☐ None
☐ Asthma
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Preterm Birth (Gestation <37 weeks)
☐ Immunosuppression, Specify: ________
☐ Cardiovascular Disease
☐ Smokes Tobacco
☐ Diabetes
☐ Kidney Disease
☐ Neurological, Specify: ________
☐ Morbidly Obese (BMI >40)
☐ Unknown
☐ Other, Specify: ________

MEDICAL COMPLICATIONS

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

CLINICAL MANAGEMENT

Was Synagis (palivizumab) prophylaxis prescribed? ☐ Y ☐ N ☐ DK

Date First Dose Received: __/__/____ Number of Doses: ______

Was Virazole (ribavirin) treatment prescribed? ☐ Y ☐ N ☐ DK

Was a corticosteroid prescribed? ☐ Y ☐ N ☐ DK

Was a bronchodilator prescribed? ☐ Y ☐ N ☐ DK

Was antibiotic treatment prescribed? ☐ Y ☐ N ☐ DK

Indication: ____________

Was mechanical ventilation used? ☐ Y ☐ N ☐ DK

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.