Influenza-Associated Hospitalization, Outpatient Visit, and Death Medical Record Abstraction Form

1) Study ID:

2) Patient status: ☐ Case ☐ Outpatient Control ☐ Hospitalized Control

3) Date completed: MM / DD / YYYY

4) Name of reviewer:

5) Specimen collection date: MM / DD / YYYY

6) Reviewer phone number: (__ __ __) __ __ __ - __ __ __ __

Basic Demographic Data (COMPLETE FOR ALL PATIENTS)

7) Patient name (last, first, middle):

8) DOB: MM / DD / YYYY

9) Age _____ ☐ Years ☐ Months

10) Sex: ☐ Male ☐ Female

11) Is the patient deceased? ☐ Yes ☐ No

11a) If yes, Date of death: MM / DD / YYYY

12) Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Not indicated in record

13) Race: (As indicated in record; check all that apply)
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Not indicated in record

14) Was the patient living in an institution? ☐ Yes ☐ No

14a) If yes, type: ☐ Long-term care facility ☐ Correctional center ☐ Other, specify:

15) Patient residence (street):

15a) City:

15b) State:

16c) ZIP:

15d) Home phone # (__ __ __) __ __ __ - __ __ __ __

15e) Cell phone # (__ __ __) __ __ __ - __ __ __ __

15f) Work phone # (__ __ __) __ __ __ - __ __ __ __

If patient is deceased or a minor:

16) Next of kin or guardian name:

17) Relationship to patient:

18) Address (street):

18a) City:

18b) State:

18c) ZIP:

18d) Home phone #: (__ __ __) __ __ __ - __ __ __ __

18e) Cell phone #: (__ __ __) __ __ __ - __ __ __ __

18f) Work phone #: (__ __ __) __ __ __ - __ __ __ __

19) Health insurance status (please check all that apply):	☐ Uninsured	☐ Medicare	☐ Medicaid	☐ IHS
	☐ Private insurance	☐ Military/VA	☐ Tribal	☐ Not indicated
	☐ Other, please specify:			

Illness Onset and Symptoms (COMPLETE FOR ALL PATIENTS)

20) Illness onset date: MM / DD / YYYY

20a) Comments:

21) Date patient first sought care from any health care provider for this illness: MM / DD / YYYY

22) Type of facility where patient first sought care: ☐ Primary care office ☐ Public health office ☐ Urgent care ☐ Hospital ER ☐ Other, specify

23) Name of facility where first sought care:

23a) City/town where facility located:

23b) ZIP:

24) Symptoms reported at time of first medical care encounter after onset: (Please check all that apply)

☐ fever: what was highest recorded temp: _____ ☐ °F ☐ °C date: MM / DD / YYYY	☐ sore throat	☐ chest pain	☐ myalgia
☐ headache	☐ new or exacerbated cough	☐ nausea	☐ malaise
☐ rhinorrhea or nasal congestion	☐ sputum production	☐ vomiting	☐ other, specify:
	☐ shortness of breath	☐ diarrhea	_____
	☐ conjunctivitis	☐ arthralgia	_____
		☐ sneezing	_____

Pre-existing Conditions (COMPLETE FOR ALL PATIENTS)

25) Asthma (incl. reactive airway disease)	☐ Yes	☐ No	☐ Not indicated in record
26) Other chronic lung disease	☐ Yes	☐ No	☐ Not indicated in record
26a) If yes, was the patient already receiving in-home oxygen therapy?	☐ Yes	☐ No	☐ Not indicated in record
27) Chronic cardiovascular disease (excl. hypertension)	☐ Yes	☐ No	☐ Not indicated in record
28) Diabetes	☐ Yes	☐ No	☐ Not indicated in record
29) Other chronic metabolic disease	☐ Yes	☐ No	☐ Not indicated in record
30) Cancer diagnosis in last 12 mos (excl. non-melanoma skin cancer)	☐ Yes	☐ No	☐ Not indicated in record
31) Renal disease	☐ Yes	☐ No	☐ Not indicated in record
32) Liver disorder	☐ Yes	☐ No	☐ Not indicated in record
33) Neurological disease	☐ Yes	☐ No	☐ Not indicated in record
34) Blood disorder	☐ Yes	☐ No	☐ Not indicated in record
35) Under age 19 years and receiving long-term aspirin therapy	☐ Yes	☐ No	☐ Not indicated in record
36) Immunosuppressive condition (HIV infection, chronic corticosteroid therapy or organ transplant recipient)	☐ Yes	☐ No	☐ Not indicated in record
37) Alcohol abuse (negative consequences from drinking alcohol)	☐ Yes	☐ No	☐ Not indicated in record

38) Other, specify:

39) Height (please indicate unit): _____ ☐ inches ☐ centimeters 40) Weight (please indicate unit): _____ ☐ pounds ☐ kilos

41) If height and weight are not available, does medical record otherwise indicate patient is obese or morbidly obese? ☐ Obese ☐ Morbidly obese ☐ Underweight ☐ Not indicated in record

41a) Please list exact words describing body habitus if available:

Pre-existing Conditions (For female patients):

42) Was patient pregnant? ☐ Yes ☐ No ☐ Not indicated in record

42a) If Yes, specify gestational age: _____ weeks OR 1st 2nd 3rd trimester

42b) Delivery date if applicable : MM / DD / YYYY

43) If pregnant and hospitalized, what was pregnancy status at time of discharge? ☐ Still pregnant ☐ No longer pregnant ☐ Not indicated in record

44) If pregnant and hospitalized, what was pregnancy outcome at time of discharge? ☐ Miscarriage/stillborn ☐ Healthy newborn ☐ Ill newborn ☐ Still pregnant ☐ Newborn died ☐ Not indicated in record

45) Was patient postpartum ≤ 2 weeks? ☐ Yes ☐ No ☐ Not indicated in record

46) Was patient postpartum > 2 weeks and ≤ 6 weeks? ☐ Yes ☐ No ☐ Not indicated in record

Outpatient Visit and Severity of Illness (COMPLETE ONLY FOR *OUTPATIENT* CONTROLS, AND CASES if applicable)

47) Outpatient facility name: 48) Date of initial visit: MM / DD / YYYY

49) Did patient have pneumonia? ☐ Yes ☐ No ☐ Not indicated in record

50) If < 5 years old, was patient breastfeeding? ☐ Yes ☐ No ☐ Not indicated in record

Hospital Admission and Severity of Illness (COMPLETE ONLY FOR *HOSPITAL* CONTROLS, AND CASES if applicable)

51) Hospital name:

51a) Location:

52) Admission Date: MM / DD / YYYY

52a) Admission time: __ __:__ __ AM or PM

53) Discharge date: MM / DD / YYYY

53a) Discharge time: __ __:__ __ AM or PM

54) Was patient transferred FROM another hospital? ☐ Yes ☐ No ☐ Not indicated in record

55) Hospital name:

55a) Hospital location:

55b) Date of transfer: MM / DD / YYYY

56) Was patient transferred TO another hospital? ☐ Yes ☐ No ☐ Not indicated in record

57) Hospital name:

57a) Hospital location:

57b) Date of transfer: MM / DD / YYYY

58) If < 5 years old, was patient breastfeeding? ☐ Yes ☐ No ☐ Not indicated in record

59) Was patient admitted to the intensive care unit? ☐ Yes ☐ No ☐ Not indicated in record

59a) Type of critical care unit: ☐ ICU ☐ PCU ☐ CCU ☐ Other:

60) Did patient require new initiation of oxygen therapy?	☐ Yes ☐ No ☐ Not indicated in record
61) Did the patient require mechanical ventilation?	☐ Yes ☐ No ☐ Not indicated in record 61a) Type ☐ ECMO ☐ Oscillator ☐ Ventilator ☐ Other:
62) Did patient have pneumonia?	☐ Yes ☐ No ☐ Not indicated in record 62a) If yes, ☐ present on admission ☐ developed during hospitalization
63) Did patient have ARDS?	☐ Yes ☐ No ☐ Not indicated in record 63a) If yes, ☐ present on admission ☐ developed during hospitalization
64) Did patient have sepsis?	☐ Yes ☐ No ☐ Not indicated in record 64a) If yes, ☐ present on admission ☐ developed during hospitalization
65) Did patient have a myocardial infarct?	☐ Yes ☐ No ☐ Not indicated in record 65a) If yes, ☐ present on admission ☐ developed during hospitalization
66) Did patient have liver failure?	☐ Yes ☐ No ☐ Not indicated in record 66a) If yes, ☐ present on admission ☐ developed during hospitalization
67) Did patient have encephalitis/encephalopathy?	☐ Yes ☐ No ☐ Not indicated in record 67a) If yes, ☐ present on admission ☐ developed during hospitalization
68) Did patient have a pulmonary embolus?	☐ Yes ☐ No ☐ Not indicated in record 68a) If yes, ☐ present on admission ☐ developed during hospitalization
69) Did patient have renal failure?	☐ Yes ☐ No ☐ Not indicated in record 69a) If yes, ☐ present on admission ☐ developed during hospitalization
70) Did patient require new initiation of dialysis?	☐ Yes ☐ No ☐ Not indicated in record 70a) If yes, ☐ present on admission ☐ developed during hospitalization
71) Did patient have DIC (disseminated intravascular coagulation)?	☐ Yes ☐ No ☐ Not indicated in record 71a) If yes, ☐ present on admission ☐ developed during hospitalization
72) Hospitalization outcome:	☐ Discharged to hospice/nursing home/long-term care facility ☐ Discharged to home ☐ Other, specify ☐ Died *If Yes, please make sure you enter Date of Death in Basic Demographics*
73) If patient died, was autopsy performed?	☐ Yes ☐ No ☐ Not indicated in record *If Yes, please attach report if available*
Laboratory Testing (COMPLETE FOR ALL PATIENTS)	
74) Rapid test (EIA) done?	☐ Yes ☐ No ☐ Not indicated in record
74a) Result:	☐ Flu A ☐ Flu B ☐ Flu A/B ☐ Negative ☐ Other, please specify:
75) Fluorescent antibody (DFA or IFA) done?	☐ Yes ☐ No ☐ Not indicated in record

75a) Result: ☐ Flu A ☐ Flu B ☐ Flu A/B ☐ Negative
☐ Other, please specify:

76) PCR done? ☐ Yes ☐ No ☐ Not indicated in record

76a) Flu A 2009 H1N1: ☐ Positive ☐ Negative ☐ Not indicated in record

77) Culture done? ☐ Yes ☐ No ☐ Not indicated in record

77a) Flu A 2009 H1N1: ☐ Positive ☐ Negative ☐ Not indicated in record

78) Collection date of first positive influenza test: MM / DD / YYYY

79) Name of lab performing first positive influenza test:
79a) Lab location:

80) Was a bacterial culture done? ☐ Yes ☐ No ☐ Not indicated in record

80a) Confirmation of bacterial infection? ☐ Yes ☐ No ☐ Not indicated in record

80b) If Yes, specify pathogen identified, specimen site/source, test type, and date collected in the Table below:

Pathogen	Site (blood, BAL, etc.)	Test (PCR, culture, rapid, etc.)	Date
1.			MM / DD / YYYY
2.			MM / DD / YYYY
3.			MM / DD / YYYY
4.			MM / DD / YYYY
5.			MM / DD / YYYY

Attach additional sheets if needed.

Radiology Testing (COMPLETE FOR ALL PATIENTS)

81) Was there radiographic evidence of any of the following: (Please check all that apply)

☐ NO radiologic testing performed
☐ ARDS
☐ Pulmonary edema
☐ Pneumonia
☐ Consolidation
☐ Report not available
☐ Cannot rule-out pneumonia
☐ Unilateral Multiple lobar infiltrate
☐ Other, specify_____
☐ Pleural effusion
☐ Bilateral Multiple lobar infiltrate
_____
☐ Interstitial infiltrate
☐ Single lobar infiltrate
_____
☐ Air space density/opacity
☐ Cavitation
_____

Medication Treatment (COMPLETE FOR ALL PATIENTS)

82) Did patient receive antiviral medications? ☐ Yes ☐ No ☐ Not indicated in record

82a) Comments:

82b) Oseltamivir (Tamiflu) ☐ Yes ☐ No ☐ Not indicated in record Start date: MM / DD / YYYY

82c) Zanamivir (Relenza) ☐ Yes ☐ No ☐ Not indicated in record Start date: MM / DD / YYYY

82d) Peramivir ☐ Yes ☐ No ☐ Not indicated in record Start date: MM / DD / YYYY

82e) Amantadine (Symmetrel) ☐ Yes ☐ No ☐ Not indicated in record Start date: MM / DD / YYYY

82f) Rimantadine (Flumadine) ☐ Yes ☐ No ☐ Not indicated in record Start date: MM / DD / YYYY

83) Did patient receive steroids? ☐ Yes ☐ No ☐ Not indicated in record

83a) If Yes, indicate route of administration: ☐ Oral ☐ IV ☐ Inhaler ☐ Not indicated in record ☐ Other, specify:

84) Did patient receive antibiotics? ☐ Yes: Please specify type and date ☐ No ☐ Not indicated in record

1)_____ Start date: MM / DD / YYYY
2)_____ Start date: MM / DD / YYYY
3)_____ Start date: MM / DD / YYYY
4)_____ Start date: MM / DD / YYYY
5)_____ Start date: MM / DD / YYYY

Attach additional sheets if needed.

85) Did patient require vasopressor medications (i.e. dopamine, epinephrine)? ☐ Yes ☐ No ☐ Not indicated in record

Vaccinations (COMPLETE FOR ALL PATIENTS)

86) Since 2008, did the patient receive an influenza vaccine? ☐ Yes ☐ No ☐ Not indicated in record

87) Did the patient receive seasonal 2008-09 influenza vaccine? ☐ Yes ☐ No ☐ Not indicated in record

87a) If received seasonal influenza vaccine, number of doses? ☐1 Date: MM / DD / YYYY ☐ 2 Date: MM / DD / YYYY ☐1 Date unknown ☐ 2 Date unknown

88) Did the patient receive seasonal 2009-10 influenza vaccine? ☐ Yes ☐ No ☐ Not indicated in record

88a) If received seasonal influenza vaccine, number of doses? ☐1 Date: MM / DD / YYYY ☐ 2 Date: MM / DD / YYYY ☐1 Date unknown ☐ 2 Date unknown

89) Did the patient receive H1N1 influenza vaccine? ☐ Yes ☐ No ☐ Not indicated in record

89a) If received H1N1 influenza vaccine, number of doses? ☐1 Date: MM / DD / YYYY ☐ 2 Date: MM / DD / YYYY ☐1 Date unknown ☐ 2 Date unknown

90) Did patient ever receive a 7-valent conjugate (Prevnar) vaccine? ☐ Yes ☐ No ☐ Not indicated in record

90a) If yes, how many doses did the patient receive? _____ number of doses ☐ Not indicated in record

90b) If yes, date of last dose ☐1 Date: MM / DD / YYYY ☐1 Date unknown ☐ Not indicated in record

91) Did patient ever receive a 23-valent polysaccharide (Pneumovax) vaccine? ☐ Yes ☐ No ☐ Not indicated in record

91a) If yes, date of last dose: ☐1 Date: MM / DD / YYYY ☐1 Date unknown ☐ Not indicated in record

Source of Data (COMPLETE FOR ALL PATIENTS)

92) Please check all that apply:

☐ Medical records ☐ State/CDC Case investigation form ☐ Laboratory list

☐ Reportable disease database ☐ Autopsy report ☐ Vaccine tracking database

☐ Other, specify _____

Please obtain and attach copies of all other records or data sources.