West Virginia Bureau for Public Health — Department of Health & Human Resources — Your Health Your Safety Our Purpose

Influenza-related Pediatric Death

1. PATIENT DEMOGRAPHICS

Name (last, first): ____________________ **Birth date**: __ / __ / ____ **Age**: _____

Address: ____________________ **Gender**: ☐Male ☐Female ☐Unk

City/State/Zip: ____________________ **Ethnicity**: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk

Phone (home): ____________ **Phone** (work) : ____________

Occupation/grade:____________ **Employer/School**:____________ **Race**: ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐Other ☐ Unk

Alternate contact: ☐Parent/Guardian ☐Spouse ☐Other

Name: ____________ *Phone:* ____________

2. INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): ____________________ **Entered in WV NBS**? ☐Yes ☐No ☐Unk

Investigator : ____________ **Investigator phone**: ____________ **WV NBS ID**: ____________

Investigation Start Date: __ / __ / ____ **Case Classification**:

Earliest date reported to LHD: __ / __ / ____ ☐ Confirmed ☐ Probable ☐ Suspect

Earliest date reported to DIDE: __ / __ / ____ ☐ Not a case ☐ Unknown

3. PHYSICIAN

Physician Name: ____________ **Physician Facility** : ____________________

Physician Address: ________________________________

Phone Number: ____________

4. CLINICAL

Onset date: __ / __ / ____ (10) **Diagnosis date**: __ / __ / ____ **Recovery date**: __ / __ / ____

Hospitalization

Y N U

☐ ☐ ☐ Hospitalized for this illness — Hospital name: ____________________

Admit date: __ / __ / ____ Discharge date: __ / __ / ____

Death

☐ ☐ ☐ Died due this illness — Date of death: __ / __ / ____ (11)

☐ ☐ ☐ Was autopsy performed? (12)

☐ ☐ ☐ Did cardiac/respiratory arrest occur outside the hospital? (13a)

Location of death____________________ (13b)

Clinical Findings

Y N U

☐ ☐ ☐ Did patient require mechanical ventilation (17)

☐ ☐ ☐ Did complications occur during the acute illness? (18a)

Y N U		Y N U	
☐ ☐ ☐	Pneumonia (x-ray confirmed)	☐ ☐ ☐	Bronchiolitis
☐ ☐ ☐	Acute Respiratory Disease Syndrome (ARDS)	☐ ☐ ☐	Sepsis
☐ ☐ ☐	Croup	☐ ☐ ☐	Encephalopathy/Encephalitis
☐ ☐ ☐	Seizures	☐ ☐ ☐	Reye syndrome
☐ ☐ ☐	Shock	☐ ☐ ☐	Another viral co-infection____________
☐ ☐ ☐	Other____________________		

☐ ☐ ☐ Did the child have any medical conditions that existed before the start of the acute illness? (19a)

If yes, check all medical conditions that existed before the start of the acute illness (19b)

☐ Moderate to severe developmental delay	☐ Hemoglobinopathy	☐ Asthma/Reactive airway disease
☐ Diabetes mellitus	☐ History of febrile seizures	☐ Seizure disorder
☐ Cystic Fibrosis	☐ Cardiac disease (specify)	☐ Renal disease (specify)
☐ Skin or soft tissue infection	☐ Chromosomal abnormality (specify)	☐ Mitochondrial disorder (specify)
☐ Chronic pulmonary disease (specify)	☐ Immunosupressive disease (specify)	☐ Metabolic disorder (specify)
☐ Neuromuscular disorder (specify, include CP)	☐ Pregnant (specify gestation age)	☐ Other

Vaccination History		
Y N U ☐ ☐ ☐ Did the patient receive any seasonal influenza vaccine during the current season (before illness) *(21)*		
If YES*, please specify the influenza vaccine received before illness onset: *(22)*	☐ Trivalent inactivated influenza vaccine (TIV) ☐ Live-attenuated influenza vaccine (LAIV) ☐ Unknown	
If YES, how many doses did the patient receive and what was the timing of each dose?*(23)* (Enter vaccination dates if available)		
☐ 1 dose only	☐<14 days prior to illness onset ☐≥14 days prior to ill	Date dose given ___/___/____
☐ 2 doses	☐ 2nd dose given <14 days prior to illness onset ☐ 2nd dose given ≥14 days prior to illness onset	Date of 1st dose ___/___/____ Date of 2nd dose ___/___/____
Y N U ☐ ☐ ☐ Did the patient receive any influenza vaccine in previous season *(24)*		
☐ ☐ ☐ If Yes, and patient ≤ 8 years of age at the time of death, did the patient receive 2 doses of vaccine during previous season? (24b)		

5.LABORATORY

CDC Laboratory Specimens

Y N U

☐ ☐ ☐ Were pathology specimens sent to CDC's Infectious Diseases Pathology Branch?*(14a)*
Lab ID if known__________________

☐ ☐ ☐ Were influenza isolates or original clinical material sent to CDC's Influenza Division? *(14b)*
Lab ID if known__________________

☐ ☐ ☐ Were *Staph aureus* isolates sent to CDC's Division of Healthcare Quality Promotion? (14c)
Lab ID if known__________________

Influenza testing (check all that apply) *(15)*

A= influenza A,
B=influenza B,
U=not distinguished,
H=2009 influenza A (H1N1), C=co-infection, specify, N=negative

A	B	U	H	C	N	Test	Collection Date
☐	☐	☐	☐	☐	☐	Commercial rapid diagnostic	Date ___/___/____
☐	☐	☐	☐	☐	☐	Viral Culture	Date ___/___/____
☐	☐	☐	☐	☐	☐	Fluorescent antibody (IFA or DFA)	Date ___/___/____
☐	☐	☐	☐	☐	☐	Enzyme Immunoassay (EIA)	Date ___/___/____
☐	☐	☐	☐	☐	☐	RT-PCR	Date ___/___/____
☐	☐	☐	☐	☐	☐	Immunohistochemistry	Date ___/___/____

Laboratory Name: ____

Laboratory Address:____

Culture Confirmation of bacterial pathogens from Sterile (Invasive) Sites

Y N U

☐ ☐ ☐ Was a specimen collected for bacterial culture from a normally sterile site (blood, CSF, tissue or pleural fluid?*(16a)*

If yes, please indicate the site from which the specimen was obtained and the result. *If more than one specimen type is positive and more than one organism is identified please indicate the organism cultured from each specimen type in the comments section*

Specimen Type	Collection Date	Result
☐ Blood	Date ___/___/____	☐ Positive ☐ Negative ☐ Unknown
☐ Pleural fluid	Date ___/___/____	☐ Positive ☐ Negative ☐ Unknown
☐ CSF	Date ___/___/____	☐ Positive ☐ Negative ☐ Unknown
☐ Other________________________	Date ___/___/____	☐ Positive ☐ Negative ☐ Unknown
☐ Unknown		

If positive, please check the organism cultured *(16c)*

☐ *Streptococcus pneumoniae*	☐ *Staphylococcus aureus*, methicillin sensitive (MSSA)	☐ *Haemophilus influenza* not-type b
☐ Group A streptococcus	☐ *Staphylococcus aureus*, methicillin resistant (MRSA)	☐ *Haemophilus influenza* type b

☐ Other bacteria______________	☐ *Staphylococcus aureus*, sensitivity not done	☐ *Pseudomonas aeruginosa*

Culture Confirmation of bacterial pathogens from Non-Sterile Sites

Y N U
☐ ☐ ☐ Were other respiratory specimens collected for bacterial culture (sputum, ET tube aspirate? *(16d)*

If yes, please indicate the site from which the specimen was obtained and the result. *If more than one specimen type is positive and more than one organism is identified please indicate the organism cultured from each specimen type in the comments section (16e)*

☐ Sputum	Date ___/___/____	☐ Positive ☐ Negative ☐ Unknown
☐ ET tube	Date ___/___/____	☐ Positive ☐ Negative ☐ Unknown
☐ Other_______________________	Date ___/___/____	☐ Positive ☐ Negative ☐ Unknown
☐ Unknown		

If positive, please check the organism cultured *(16f)*

☐ *Streptococcus pneumoniae*	☐ *Staphylococcus aureus*, methicillin sensitive (MSSA)	☐ *Haemophilus influenza* not-type b
☐ Group A streptococcus	☐ *Staphylococcus aureus*, methicillin resistant (MRSA)	☐ *Haemophilus influenza* type b
☐ Other bacteria______________	☐ *Staphylococcus aureus*, sensitivity not done	☐ *Pseudomonas aeruginosa*

Pathology confirmation of bacterial pathogens

Y N U
☐ ☐ ☐ Was a specimen (e.g., fixed lung tissue) collected from an autopsy for testing of bacterial pathogens by a local or state pathologist? *(If pathology results are available from CDC it is not necessary to input those results here, however please make sure to complete section "CDC Laboratory Specimens")* (16g)

If yes, please indicate the results of these tests in the comments section at the end of the form

Specimen source: _____________

Notes (clinical or laboratory)	

5. INFECTION TIMELINE

Instructions: Enter onset date in grey box. Count backward to determine probable exposure period		Exposure period			Onset date
	***Days** from onset*	**-7** *(Max Incubation)*	**-1** *(Min Incubation)*		⇩
	Calendar dates:	__ / __ / ____	__ / __ / ____	⇦	__ / __ / ____

6. EPIDEMIOLOGIC

Was the patient receiving any of the following therapies prior to illness onset? *(20a)*	
☐ Aspirin or aspirin containing products	☐ NSAID or NSAID-containing products
Was the patient receiving any of the following therapies prior to illness onset? *(20b)*	
☐ Antiviral Prophylaxis	☐ Chemotherapy or radiation therapy
☐ Steroids by mouth or injection	☐ Other immunosuppressive therapy ____________________
Was the patient receiving any of the following therapies after illness onset? (check all that apply) *(20c)*	
☐ Antibiotic therapy specify ___________________________	☐ Antiviral therapy specify ____________________________

7. PUBLIC HEALTH ISSUES	**8. PUBLIC HEALTH ACTIONS**
Y N NA	Y N NA
☐ ☐ ☐ Failure to vaccinate	☐ ☐ ☐ Notified CDC
☐ ☐ ☐ Failure of vaccine	☐ ☐ ☐ Notified state health department
☐ ☐ ☐ Vaccine mismatch	☐ ☐ ☐ Case isolated
☐ ☐ ☐ Seasonal	
☐ ☐ ☐ Novel	

NOTES