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

Influenza Severe Illness or Death in Pregnant or Post-Partum Women

PATIENT DEMOGRAPHICS

Name (last, first): _____ **Birth date**: __ / __ / ____ **Age**: _____
Address: **Gender**: ☐Male ☐Female ☐U

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

_____
Phone (home): _____ **Phone** (work) : _____ ☐Hispanic or Latino ☐U
Occupation/grade:_____ **Employer/School**:_____ **Race**: ☐ White ☐Black/Afr. Amer.
Alternate contact: ☐*Parent/Guardian* ☐ *Spouse* ☐*Other* ☐Asian ☐Am. Ind/AK Native
Name: _____ *Phone:* _____ ☐Native HI/Other PI
☐Other ☐ Unknown

Insurance type (3) **:**
☐ Self-pay ☐ Private health insurance
☐ Uninsured ☐ Medicaid
☐ Unknown

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____ **Entered in WVEDSS**? ☐Yes ☐No ☐Unk
Investigator : _____ **Investigator phone**: _____ **WVEDSS ID**: _____
Investigation Start Date: __ / __ / ____ **Case Classification**:
Earliest date reported to LHD: __ / __ / ☐ Confirmed ☐ Probable ☐ Suspect
____
Earliest date reported to DIDE: __ / __ / ____ ☐ Not a case ☐ Unknown

PHYSICIAN

Physician Name: _____ **Physician Facility** : _____
Physician Address: _____
Phone Number: _____

CLINICAL

Onset date (9) : __ / __ / ____ **Diagnosis date**: __ / __ / ____ **Recovery date**: __ / __ / ____

Y	N	U	
☐	☐	☐	Notation in medical record of "high risk" pregnancy classification (4)

Hospitalization

☐	☐	☐ Hospitalized for this illness (18)

Hospital name & address: _____

Admit date: __ / __ / ____ (18) Discharge date: __ / __ / ____

Y	N	U	
☐	☐	☐	Admitted to ICU? (19)

☐ ☐ ☐ More than one ICU admission (e.g. transfer or readmission) for this illness? (20)

Date of initial ICU admission (21) __ / __ / ____

Total days in ICU (22) _____

Date of hospital discharge/death (23) __ / __ / ____

Y	N	U	
☐	☐	☐	Maternal death (24)

☐ ☐ ☐ Underlying medical conditions/risk factors (5) Check all that apply

☐ None
☐ Asthma
☐ Other chronic lung disease
☐ Metabolic disorder
☐ Gestational diabetes
☐ Obesity (prior to pregnancy

☐ Cardiovascular disease, excluding hypertension			
☐ Hypertension (prior to pregnancy)			
☐ Gestational hypertension/Preeclampsia/eclampsia			
☐ Neurological disorder including seizure disorder			
☐ Tobacco use during pregnancy			
☐ Immunosuppression, specify_____			
☐ Cancer diagnosed in last year			
☐ Hematologic disorder (e.g. hemoglobinopathy)			
☐ Hepatic disorder			
☐ Substance abuse during current pregnancy (e.g. alcohol, illegal drug use)			
☐ Psychiatric disorder			
☐ Renal disease			
☐ Other, specify			
☐ Unknown			
Prenatal medications upon admission to hospital (6)			
Y N U ☐ ☐ ☐ Other medications during hospitalization(s) if yes check all that apply (25)			
☐ Vasopressors	☐ Antibiotics	☐ Antihypertensives	
☐ Systemic corticosteroids, if yes, specify reason (maternal health or fetal lung maturity) _____			
☐ Nebulized drugs (e.g. albuterol)	☐ Antiepileptics	☐ Antiglycemics	
☐ Tocolytic agents	☐ Diuretics	☐ Narcotic analgesic	
☐ Sedative	☐ Antifungal	☐ Other	
☐ ☐ ☐ Was she diagnosed with pneumonia? (26)		☐ Yes date ___ / ___ / _____	
If pneumonia, check all known types/results of respiratory cultures. List organisms if known			
Y N U ☐ ☐ ☐ Bacterial	P N U ☐ ☐ ☐		
☐ ☐ ☐ Viral	☐ ☐ ☐		
☐ ☐ ☐ Fungal	☐ ☐ ☐		
☐ ☐ ☐ ARDS?	Yes date ___ / ___ / _____		
☐ ☐ ☐ Did she require mechanical ventilation(27)	Date of intubation ___ / ___ / _____	Number of days_____	

Pregnancy			
Estimated due date (7)		___ / ___ / _____	
Gestational age at admission (weeks) _____ (8)			
Y N U ☐ ☐ ☐ Multiple gestation? (e.g. twins, triplets) Number _____ **Note: if multiple gestation pregnancy fill out clinical information on each infant**			
Date of delivery (spontaneous/elective abortion): (28)		___ / ___ / _____	
Delivery location (29)			
☐ Labor and delivery	☐ Emergency department	☐ Intensive care unit	
☐ Other (specify) _____		☐ Unknown	
Method of delivery (30)			
☐ Undelivered	☐ Vaginal	☐ Cesarean	
☐ Cesarean, emergency	☐ Cesarean, unknown if scheduled or emergency	☐ Unknown	
Other delivery details/complications: (31)			
Outcome (32)			
☐ Live birth	☐ Still birth	☐ Spontaneous abortion	

☐ Undelivered fetal demise		☐ Unknown	
☐ ☐ ☐ Did the mother take antiviral medications after becoming ill (check all that apply)? **(17)**			
☐ Oseltamivir			
☐ Zanamivir			
☐ Rimantadine			
☐ Amantadine			
☐ IV Peramivir			
☐ Other			
☐ Unknown antiviral			

Infant Clinical Information

Gestational age at delivery (weeks) (34) : _____			
Infant birth weight (35) : _____		Date of infant hospital discharge (41) ___ / ___ / _____	
Y N U ☐ ☐ ☐ Infant 1-minute apgar _____ (36)			
☐ ☐ ☐ Infant 5-minute apgar _____ (37)			
☐ ☐ ☐ Infant to NICU (38)		Date of NICU discharge ____ / ___ / _____	
☐ ☐ ☐ Infant death? **(42)**		Date of infant death (41) ___ / ___ / _____	
Infant conditions during hospitalization (43)			
☐ None	☐ Skin rash	☐ Fever	
☐ Bradycardia	☐ Apnea	☐ Petechiae	☐ Temperature instability
☐ Cataracts	☐ Seizures	☐ Meningitis	☐ Chorioretinitis
Infant Outcome (any details regarding isolation, antivirals, or complications) **(48)** **:**			
Narrative (any relevant additional information on mother and/or infant) (49)			

VACCINATION HISTORY

Y N U ☐ ☐ ☐ **Did mother receive any influenza vaccine in 2010 or 2011 more than 2 weeks before onset of illness? (16)**
If yes, 2009 pandemic seasonal flu
☐ ☐ ☐ 2009 pandemic H1N1 vaccine
☐ ☐ ☐ 2010-2011 seasonal flu vaccine

LABORATORY

Laboratory Name: _____

Laboratory Address:_____

Test Y N U	Result P N U
☐ ☐ ☐ Did the mother receive rapid influenza test? (11)	☐ ☐ ☐
☐ ☐ ☐ Did the mother receive rRT-PCR? (12)	☐ ☐ ☐
☐ ☐ ☐ Did the mother have any viral cultures? (13)	☐ ☐ ☐
☐ ☐ ☐ Did the mother receive DFA/IFA test? (14)	☐ ☐ ☐
Did influenza testing confirm any influenza type or subtype? **(15)**	
☐ Yes – Flu A identified/Subtype identified	

☐ Yes - Flu A identified/unknown Subtype	
☐ Yes - Flu B identified	
☐ Yes - Flu C identified	
☐ No flu type known	
Y N U	Result P N U
☐ ☐ ☐ Did infant receive rapid influenza test? (44)	☐ ☐ ☐
☐ ☐ ☐ Did infant receive rRT-PCR? (45)	☐ ☐ ☐
☐ ☐ ☐ Did infant have any viral cultures? (46)	☐ ☐ ☐
☐ ☐ ☐ Did infant receive DFA/IFA test? (47)	☐ ☐ ☐

Notes (clinical)	Notes (laboratory)

INFECTION TIMELINE

Instructions: *Enter onset date in grey box. Count backward to determine probable exposure period*

EPIDEMIOLOGIC					Onset date
	Days from onset	***-7 (Max Incubation)***	***-1 (Min Incubation)***		⇩
	Calendar dates:	__ / __ / ____	__ / __ / ____		__ / __ / ____

	___ / ___ / _____	☐ Unknown
		☐ Unknown
		Number_____

1. PUBLIC HEALTH ISSUES

Y N U		Y N U	
☐ ☐ ☐	Failure to vaccinate	☐ ☐ ☐	Isolated
☐ ☐ ☐	Failure of vaccine	☐ ☐ ☐	Patient and contacts educated
☐ ☐ ☐	Vaccine mismatch		
☐ ☐ ☐	Novel		
☐ ☐ ☐	Seasonal		

NOTES