# Influenza Death

County

Case name (last, first) ______
Birth date ___/___/___ Sex at birth ☐ F ☐ M ☐ Other Alternate name ______
Phone ______ Email ______
Address type ☐ Home ☐ Mailing ☐ Other ☐ Temporary ☐ Work
Street address ______
City/State/Zip/County ______
Residence type (incl. Homeless) ______ WA resident ☐ Yes ☐ No

## ADMINISTRATIVE

**Investigator** ______
LHJ Case ID (optional) ______
**LHJ notification date** ___/___/___

**Classification** ☐ Classification pending ☐ Confirmed
☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

Investigation status
☐ In progress
☐ Complete
☐ Complete – not reportable to DOH
☐ Unable to complete Reason ______

**Investigation start date** ___/___/___
Investigation complete date ___/___/___
**Case complete date** ___/___/___

Outbreak related ☐ Yes ☐ No
LHJ Cluster ID ______ Cluster Name ______

## DEMOGRAPHICS

Age at symptom onset ______ ☐ Years ☐ Months
**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk
**Race** (check all that apply) ☐ Unk ☐ Amer Ind/AK Native
☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other ______
Employed ☐ Yes ☐ No ☐ Unk Occupation ______
Industry ______ Employer ______
Work site ______ City ______
Student/Day care ☐ Yes ☐ No ☐ Unk
Type of school ☐ Preschool/day care ☐ K-12 ☐ College
☐Graduate School ☐ Vocational ☐ Online ☐ Other
School name ______
School address ______
City/State/County ______ Zip ______
Phone number ______ Teacher's name ______

## REPORT SOURCE

**Initial report source** ______
LHJ ______
Reporter organization ______
Reporter name ______
Reporter phone ______

All reporting sources (list all that apply)
______
______
______

## COMMUNICATIONS

Primary HCP name ______
Phone ______
Alternate contact ☐ Parent/Guardian ☐ Spouse/Partner
☐Friend ☐ Other ______
Contact name ______
Contact phone ______

## CLINICAL INFORMATION

Symptom Onset ___/___/___ ☐ Derived Diagnosis date ___/___/___
Is this case a pediatric flu death (case under age 18 years) ☐ Yes ☐ No ☐ Unk If yes, complete ALL sections of this form

**Clinical Features and Complications**

**Y N Unk**
☐ ☐ ☐ Any fever, subjective or measured Temp measured? ☐ Yes ☐ No Highest measured temp ______ ºF
☐ ☐ ☐ Cough Onset date ___/___/___
☐ ☐ ☐ Croup
☐ ☐ ☐ Diarrhea *(3 or more loose stools within a 24 hour period)*
☐ ☐ ☐ Dyspnea (shortness of breath)
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Pharyngitis (sore throat)
☐ ☐ ☐ Pneumonia
Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider Only
Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Not tested ☐ Other ______
☐ ☐ ☐ Illness clinically compatible with influenza infection
☐ ☐ ☐ Seizure new with disease
☐ ☐ ☐ Acute respiratory distress syndrome (ARDS) Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider only
☐ ☐ ☐ Neurologic/neurodevelopmental disorder ______

**Y N Unk**

- ☐ ☐ ☐ Any other complication ________________________________
- ☐ ☐ ☐ Another viral co-infection ________________________________

*Pediatric Death Only*

**Y N Unk**

- ☐ ☐ ☐ Bronchiolitis
- ☐ ☐ ☐ Encephalitis or encephalomyelitis
- ☐ ☐ ☐ Hemorrhagic pneumonia/pneumonitis
- ☐ ☐ ☐ Myocarditis
- ☐ ☐ ☐ Reye syndrome
- ☐ ☐ ☐ Shock
- ☐ ☐ ☐ Sepsis syndrome
- ☐ ☐ ☐ Did cardiac/respiratory arrest occur outside the hospital

**Predisposing Conditions**

**Y N Unk**

- ☐ ☐ ☐ Alcohol or drug abuse
- ☐ ☐ ☐ Cancer diagnosis or treatment in 12 months prior to onset ________________________________
- ☐ ☐ ☐ Cardiac disease/congenital heart disease
- ☐ ☐ ☐ Chronic kidney disease
- ☐ ☐ ☐ Chronic liver disease
- ☐ ☐ ☐ Chronic lung disease (e.g., COPD, emphysema)
- ☐ ☐ ☐ Current tobacco smoker
- ☐ ☐ ☐ Diabetes mellitus
- ☐ ☐ ☐ HIV positive/AIDS
- ☐ ☐ ☐ Non-cancer immunosuppressive condition
- ☐ ☐ ☐ Chemotherapy
- ☐ ☐ ☐ Steroid therapy
- ☐ ☐ ☐ Cognitive abnormality
- ☐ ☐ ☐ Obesity Height (in inches) _______ Weight (in pounds) _______
- ☐ ☐ ☐ Organ transplant
- ☐ ☐ ☐ Other immunosuppressive condition ________________________________
- ☐ ☐ ☐ Neuromuscular disorder (e.g., muscular dystrophy) ________________________________
- ☐ ☐ ☐ Other underlying medical conditions ________________________________

*Pediatric Death Only*

**Y N Unk**

- ☐ ☐ ☐ Asthma/reactive airway disease
- ☐ ☐ ☐ Hemoglobinopathy (e.g., sickle cell disease)
- ☐ ☐ ☐ Cerebral palsy
- ☐ ☐ ☐ Cystic fibrosis
- ☐ ☐ ☐ Moderate to severe developmental delay
- ☐ ☐ ☐ History of febrile seizures
- ☐ ☐ ☐ Chromosomal abnormality/genetic syndrome ________________________________
- ☐ ☐ ☐ Antiviral prophylaxis
- ☐ ☐ ☐ Chronic aspirin therapy
- ☐ ☐ ☐ Chemotherapy or radiation therapy
- ☐ ☐ ☐ Steroids by mouth of injection
- ☐ ☐ ☐ Other immunosuppressive therapy ________________________________
- ☐ ☐ ☐ History of seizures
- ☐ ☐ ☐ Mitochondrial disorder ________________________________
- ☐ ☐ ☐ Premature at birth Gestational age in weeks _______
- ☐ ☐ ☐ Skin or soft tissue infection
- ☐ ☐ ☐ Endocrine disorder ________________________________
- ☐ ☐ ☐ Other neurological disorder ________________________________

**Pregnancy**

Pregnancy status at time of symptom onset

☐ Pregnant Weeks pregnant at any symptom onset _______

Outcome of pregnancy ☐ Still pregnant ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other ________________________________
☐ Delivered – full term ☐ Delivered – preemie ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk

☐ Postpartum

Outcome of pregnancy ☐ Fetal death (miscarriage or stillbirth) ☐ Abortion
☐ Other ________________________________
☐ Delivered – full term ☐ Delivered – preemie ☐ Delivered – Unk
Delivery method ☐ Vaginal ☐ C-section ☐ Unk

☐ Neither pregnant nor postpartum ☐ Unk

Case Name ___________________________________ LHJ Case ID ___________________________________

**Vaccination**

**Y N Unk**

☐ ☐ ☐ Influenza vaccine during the current season (before illness)

First dose date ☐ Less than 14 days prior to illness onset ☐ Fourteen or more days prior to illness onset

Vaccine type ☐ Inactivated influenza vaccine (IIV3) [injected] ☐ Quadrivalent inactivated influenza vaccine (IIV4) [injected]

☐ Live-attenuated influenza vaccine (LAIV4) [nasal spray] ☐ Unk

Second dose date ☐ Less than 14 days prior to illness onset ☐ Fourteen or more days prior to illness onset ☐ Not given

Vaccine type ☐ Inactivated influenza vaccine (IIV3) [injected] ☐ Quadrivalent inactivated influenza vaccine (IIV4) [injected]

☐ Live-attenuated influenza vaccine (LAIV4) [nasal spray] ☐ Unk

Vaccine information available ☐ Yes ☐ No Date of vaccine administration ___/___/___

Vaccine lot number ___________________________________ Administering provider ___________________________________

Sources reviewed (check all the apply) ☐ Patient's immunization record ☐ Medical records ☐ Coroner's report

☐ Immunization information system (registry) ☐ Parent report ☐ News/media report

☐ Other _____________________________________

*Pediatric Death Only*

**Y N Unk**

☐ ☐ ☐ Influenza vaccine in previous season

☐ ☐ ☐ Received 2 doses of vaccine during a previous season (if patient was less than 8 years of age at the time of death)

**Clinical Testing** - *Pediatric Death Only*

**Y N Unk**

☐ ☐ ☐ Pathology specimens sent to CDCs Infectious Disease Pathology Branch Lab ID ______________________________

☐ ☐ ☐ Influenza isolates or original clinical material sent to CDCs Influenza Division Lab ID ______________________________

☐ ☐ ☐ Were other respiratory specimens collected for bacterial culture (e.g., sputum, ET tube aspirate) Specify ____________

☐ ☐ ☐ Was a specimen collected for bacterial culture from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid? *Specimens collected greater than 24 hours after death are not sterile*

**Hospitalization**

**Y N Unk**

☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name _____________________________________

Hospital admission date ___/___/___ Discharge ___/___/___

☐ ☐ ☐ Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___

☐ ☐ ☐ Mechanical ventilation or intubation required

**Y N Unk**

☐ ☐ ☐ **Died of this illness** Death date ___/___/___ *Please fill in the death date information on the Person Screen*

☐ ☐ ☐ Autopsy performed

☐ ☐ ☐ Specimens available

☐ ☐ ☐ Was a specimen (e.g., fixed lung tissue) collected from an autopsy for testing of bacterial pathogens by a local or state pathologist?

☐ ☐ ☐ Death certificate lists disease as a cause of death or a significant contributing condition

☐ ☐ ☐ Health care visit prior to death

Location of death ☐ Outside of hospital (e.g., home or in transit to the hospital

☐ Emergency department (ED) ☐ Inpatient ward ☐ ICU

☐ Other _____________________________________

**RISK AND RESPONSE (Ask about exposures 1-7 days before symptom onset)**

**Travel**

| | Setting 1 | Setting 2 | Setting 3 |
|---|---|---|---|
| Travel out of: | ☐ County/City ________________<br>☐ State ____________________<br>☐ Country __________________<br>☐ Other ____________________ | ☐ County/City ________________<br>☐ State ____________________<br>☐ Country __________________<br>☐ Other ____________________ | ☐ County/City ________________<br>☐ State ____________________<br>☐ Country __________________<br>☐ Other ____________________ |
| Destination name | | | |
| Start and end dates | ___/___/___ to ___/___/___ | ___/___/___ to ___/___/___ | ___/___/___ to ___/___/___ |

**Risk and Exposure Information**

**Y N Unk**

☐ ☐ ☐ Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country ______________________________

☐ ☐ ☐ Antiviral therapy received after illness onset _____________________________________

☐ ☐ ☐ (Potential) Occupational exposure

**Exposure and Transmission Summary**

Likely geographic region of exposure ☐ In Washington – county ______________ ☐ Other state ______________

☐ Not in US - country _______________ ☐ Unk

Case Name ____________________ LHJ Case ID ____________________

International travel related ☐ During entire exposure period ☐ During part of exposure period ☐ No international travel
Suspected exposure setting ☐ Day care/Childcare ☐ School (not college) ☐ Doctor's office ☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient facility ☐ Home ☐ Work ☐ College ☐ Military ☐ Correctional facility ☐ Place of worship
☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter ☐ International travel ☐ Out of state travel ☐ Transit
☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Hotel/motel/hostel ☐ Other ____________________
Describe ____________________
Exposure summary

Suspected transmission setting (check all that apply) ☐ Day care/Childcare ☐ School (not college) ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER ☐ Hospital outpatient facility ☐ Home ☐ Work ☐ College ☐ Military
☐ Correctional facility ☐ Place of worship ☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter
☐ International travel ☐ Out of state travel ☐ Transit ☐ Social event ☐ Large public gathering ☐ Restaurant
☐ Hotel/motel/hostel ☐ Other ____________________
Describe ____________________

**Public Health Interventions/Actions**

**Y N Unk**
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___
☐ ☐ ☐ Any other public health action ____________________

## TREATMENT

Did patient receive prophylaxis/treatment ☐ Yes ☐ No ☐ Unk
Specify antiviral ____________________
Prescribed dose _______ ☐ g ☐ mg ☐ ml Frequency _______ Duration _______ ☐ Days ☐ Weeks ☐ Months

## NOTES

## LAB RESULTS

Lab report information
**Lab report reviewed – LHJ** ☐
WDRS user-entered lab report note

Submitter ____________________
Performing lab for entire report____________________
Referring lab ____________________

Specimen
**Specimen identifier/accession number** ____________________
**Specimen collection date** ___/___/___ Specimen received date ___/___/___
**WDRS specimen type** ____________________
WDRS specimen source site ____________________
WDRS specimen reject reason ____________________

Test performed and result
**WDRS test performed** ____________________
**WDRS test result, coded** ____________________
WDRS test result, comparator _______
**WDRS result, numeric only** (enter only if given, including as necessary ***Comparator*** and ***Unit of measure***) _______
WDRS unit of measure _______
Test method ____________________
WDRS interpretation code ____________________
Test result – Other, specify ____________________
**WDRS result summary** ☐ Positive ☐ Negative ☐ Indeterminate ☐ Equivocal ☐ Test not performed ☐ Pending
Test result status ☐ Final results; Can only be changed with a corrected result
☐ Preliminary results
☐ Record coming over is a correction and thus replaces a final result
☐ Results cannot be obtained for this observation
☐ Specimen in lab; results pending
Result date ___/___/___
**Upload document**

Ordering Provider
WDRS ordering provider ____________________

Ordering facility
WDRS ordering facility name ____________________