

Ohio Department of Health
Influenza-Associated Hospitalization
Confidential Case Report

Person demographics

ODRS ID number			
Last name		First name	Middle name
Street			County
City		State	ZIP
Date of birth / /		Age	Phone number ()
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian Native or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Non Latino <input type="checkbox"/> Unknown
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of death / /	

Laboratory information

Test type	Result	Specimen collection date
<input type="checkbox"/> Commercial rapid diagnostic test	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A/B (Not distinguished)	/ /
<input type="checkbox"/> Viral culture	<input type="checkbox"/> Influenza A (Subtyping not done) <input type="checkbox"/> Negative <input type="checkbox"/> Influenza B <input type="checkbox"/> Influenza A (Unable to subtype) <input type="checkbox"/> Influenza A Seasonal (H1) <input type="checkbox"/> Influenza A (H3) <input type="checkbox"/> Influenza A (2009) H1N1	/ /
<input type="checkbox"/> Direct fluorescent antibody (DFA)	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A/B	/ /
<input type="checkbox"/> Indirect fluorescent antibody (IFA)	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative <input type="checkbox"/> Influenza A/B	/ /
<input type="checkbox"/> Enzyme immunoassay (EIA)	<input type="checkbox"/> Influenza A (Subtyping not done) <input type="checkbox"/> Negative <input type="checkbox"/> Influenza B <input type="checkbox"/> Influenza A (Unable to subtype) <input type="checkbox"/> Influenza A Seasonal (H1) <input type="checkbox"/> Influenza A (H3) <input type="checkbox"/> Influenza A (2009) H1N1	/ /
<input type="checkbox"/> RT-PCR	<input type="checkbox"/> Influenza A (Subtyping not done) <input type="checkbox"/> Negative <input type="checkbox"/> Influenza B <input type="checkbox"/> Influenza A (Unable to subtype) <input type="checkbox"/> Influenza A Seasonal (H1) <input type="checkbox"/> Influenza A (H3) <input type="checkbox"/> Influenza A (2009) H1N1	/ /
<input type="checkbox"/> Rapid Molecular Assay	<input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Negative	/ /

Date of illness onset / /	Clinician name	Clinician phone # ()	
Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Hospital	Date of admission / /	
Date of discharge / /	Medical record number	Does patient have neurological symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Was the patient in the ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Culture confirmation of *invasive* bacterial pathogens

Was an invasive bacterial infection confirmed by culturing an organism from a specimen collected from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid)?

Yes No

Streptococcus pneumoniae *Staphylococcus aureus*, methicillin **sensitive**

Haemophilus influenzae type b *Staphylococcus aureus*, methicillin **resistant (MRSA)**

Haemophilus influenzae not-type b *Staphylococcus aureus*, **sensitivity not done**

Group A streptococcus *Neisseria meningitidis* (serogroup, if known) _____

Other invasive bacteria _____

Epidemiology information

Did patient travel out of the country during the 10 days prior to illness? Yes No Unknown

If yes, then list where and when:

is the patient a healthcare worker with direct patient contact? Yes No Unknown
 Does the patient have a heart, kidney, or metabolic disorder? Yes No Unknown
 Does the patient have a chronic respiratory disorder? Yes No Unknown
 Is the patient immunosuppressed? Yes No Unknown

Vaccination information

Did patient receive an influenza vaccine during the current influenza season? Yes No Unknown

If yes, number of doses:	Date of vaccination: / /	Date of vaccination: / /	Date of vaccination: / /
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