<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TIBDN INFLUENZA SURVEILLANCE FORM</strong></td>
<td><strong>Hospital Acquired Influenza (v.1.2 Dec, 2005)</strong></td>
<td><strong>TIBDN ID:______</strong></td>
</tr>
<tr>
<td>1)</td>
<td>Patient Initials</td>
<td>2) Sex: ☐ Male ☐ Female</td>
</tr>
<tr>
<td>3)</td>
<td>DOB: _____________________</td>
<td>(dd/month/yyyy)</td>
</tr>
</tbody>
</table>

**INFLUENZA ONSET AND HOSPITAL ADMISSION**

6) Date of symptom onset: ______________________ (dd/month/yyyy)
   (include fever and specific upper respiratory symptoms in days before test positive for influenza)

   1. Time of onset: (from the chart) _________ (hh:mm), or *estimated _________
      * estimated time (day, morning, evening, night)

7N) Date admitted to hospital ______________________ (dd/month/yyyy)

8N) Admission Diagnosis:

9N) Location in the hospital at the time of influenza symptom onset:
💼 ICU ☐ Medical/Surgical Ward ☐ Long Term Care (Rehab) Floor ☐ Unknown

10) Outcome:
☐ Survived, date of discharge ______________________
☐ Died, Date of death ______________________ Time: _________ (hh:mm)

11) Cause of Death (from death certificate):

   Comment re: cause of death: based on MD notes, would the patient have died even if he/she had not had influenza? ☐ Yes ☐ No

12) Is this infection associated with an institution? ☑ Yes, nosocomial* (marked for data entry purposes)

   *Nosocomial Cases - Onset of influenza illness is >=48 hours after hospital admission

   FOR CASES acquired in a hospital, but discharged, and readmitted with influenza use the form for Community-Acquired Influenza

**LABORATORY TESTING FOR INFLUENZA**

13) Date influenza positive specimen collected: ______________________ (dd/month/yyyy)

14) Type of specimen:
☐ NP swab ☐ Throat swab ☐ Sputum ☐ BAL ☐ Auger Suction/NP aspirate
☐ Other (specify)

15) Lab Tests: (check all available tests results)
   Shell vial or tube viral culture ☐ Pos ☐ Neg ☐ Not found
   Direct fluorescent antibody (DFA) ☐ Pos ☐ Neg ☐ Not found
   Enzyme immunoassay (EIA) eg. Becton Dickinson ☐ Pos ☐ Neg ☐ Not found

16) Type influenza: ☐ Influenza A ☐ Influenza B ☐ A/B (not distinguished) ☐ can’t find on chart
17) Results of Cultures done within 3 DAYS (+/- 3) of test positive for Influenza (anything OTHER than influenza)

<table>
<thead>
<tr>
<th>Culture Type</th>
<th>not done</th>
<th>Neg</th>
<th>Pos</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pleural fluid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Throat swab</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sputum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronch. Specimen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NP swab</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

VRE/MRSA screen:
- not done
- Neg
- Pos

Is the patient known to be MRSA positive?
- Yes
- No

Is the patient known to be VRE positive?
- Yes
- No

Other, specify:
- not done
- Neg
- Pos

18) APACHE II Score (values are the WORST measurement taken within 24 HOURS of TEST POSITIVE for Influenza)

<table>
<thead>
<tr>
<th>Measurement</th>
<th>High Abnormal Range</th>
<th>Low Abnormal Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature (C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure (Systolic /Diastolic)</td>
<td>Record most extreme BP; normal BP for adults usually fall in the range 90/60 – 130/80.</td>
<td></td>
</tr>
<tr>
<td>Heart Rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Oxygenation:
- FIO2
- PaO2 (mmHg)
- PaCO2 (mmHg)

Arterial pH

Serum HCO3 (venous mEq/L)

Serum Sodium (mEq/L)

Serum Potassium (mEq/L)

Serum Creatinine (mmol/L)

Hematocrit (%)

White Blood Count (x 10^9/L)

S_0_2O_2 (%) (Oxygen Saturation)

18A) Glasgow Coma Score (circle the corresponding score)

<table>
<thead>
<tr>
<th>Eye Opening</th>
<th>Best Verbal Response</th>
<th>Best Motor Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) None</td>
<td>(1) None</td>
<td>(1) None</td>
</tr>
<tr>
<td>(2) To Pain</td>
<td>(2) Incomprehensible</td>
<td>(2) Abnormal Extension to Pain</td>
</tr>
<tr>
<td>(3) To Speech</td>
<td>(3) Inappropriate Words</td>
<td>(3) Abnormal Flexion to Pain</td>
</tr>
<tr>
<td>(4) Spontaneous</td>
<td>(4) Confused</td>
<td>(4) Withdraws to Pain</td>
</tr>
<tr>
<td></td>
<td>(5) Oriented</td>
<td>(5) Localized Pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(6) Obey’s Commands</td>
</tr>
</tbody>
</table>

Can not tell
### 19) PRIOR CHRONIC ILLNESS

<table>
<thead>
<tr>
<th>None</th>
<th>Yes</th>
</tr>
</thead>
</table>
| ☐ Diabetes mellitus with retinopathy, neuropathy or renal failure (creatinine >200)  
☐ Diabetes mellitus, no complications  
| ☐ Angina  
☐ Arrhythmia  
☐ Valvular  
| ☐ Previous myocardial infarction (cases that have history of definite or probable myocardial infarction, who have been hospitalized and had electrocardiographic or enzyme changes)  
☐ Congestive heart failure  
☐ Coronary artery disease  
☐ Other cardiac (specify)  
| ☐ Peripheral vascular (including claudication; had bypass for arterial insufficiency; w/untreated thoracic or abdominal aneurysm (6 cm or more), gangrene or acute arterial insufficiency)  
☐ Hypertension  
☐ Cerebrovascular (includes cases w/history of a stroke with minor or no residual; and transient ischemic attacks)  
☐ Other vascular (specify):  
| ☐ Asthma  
☐ COPD (Chronic Obstructive lung disease, Emphysema, Chronic Bronchitis)  
☐ Other pulmonary (specify):  
| ☐ Chronic renal failure (creatinine >200)  
| ☐ Nephrotic syndrome  
☐ Kidney transplant  
☐ Other renal (specify)  
| ☐ Yes  ☐ No  
Does the patient require constant oxygen supply?  
If no, is the patient dyspneic?  
| ☐ Yes, at rest  
☐ Yes, at moderate activity  
☐ No  
| ☐ Dementia  
☐ Cerebral palsy  
☐ Hemiplegia or paraplegia  
☐ Seizure disorder  
☐ Spinal cord injury  
☐ Chronic cerebrospinal fluid leak  
☐ Amyotrophic disorder  
☐ Other neuromuscular (specify)  

---

documented creatinine before influenza: ____________

Is the patient Dialysis dependent?
## Cont 19. PRIOR CHRONIC ILLNESS

### LIVER

- □ Chronic hepatitis
- □ Hepatic cirrhosis (any cause)
- □ Other liver, Specify

  Has the patient the following sequelae of a liver disease?
  - □ Yes  □ No  Hepatic coma
  - □ Yes  □ No  Portal hypertension
  - □ Yes  □ No  History of bleeding esophageal varices (variceal bleeding)

### GASTROINTESTINAL

- □ Inflammatory bowel disease (patients with ulcerative colitis or regional enteritis)
- □ Peptic ulcer (cases who have required treatment for ulcer disease, including those who have bleed from ulcers)
- □ GI bleeding, except bleeding from peptic ulcer (cases who have had bleeding requiring transfusions from causes other than ulcer disease)
- □ Other gastrointestinal, specify

### CANCER

- □ Metastatic solid tumor (with documented metastasis); Specify organ: ________________________________

- □ Solid Tumor (without documented metastasis) Specify organ: ________________________________
  - □ Yes  □ No  Was the solid tumor initially treated in the last 5 years?

- □ Lymphoma (patients with Hodgkins disease, lymphosarcoma, Waldensrorn', macroglobulinemia, myeloma, and other lymphomas)
  - mark here if  □ Hodgkins disease  □ Multiple myeloma

- □ Leukemia
  - If leukemia specify:  □ Acute  □ Chronic

- □ Other cancer (specify)

### RHEUMATOLOGIC

- □ Scleroderma
- □ Systemic lupus erythematosus
- □ Polymyositis
- □ Rheumatoid arthritis
- □ Mixed connective tissue disease
- □ Moderate to severe arthritis
- □ Other rheumatoid disease or vasculitis, specify

- □ HIV infection
  - □ Check, if AIDS
    - Most recent CD4 count  ______________

- □ Sickle cell disease
- □ Other hemoglobinopathy, specify:
- □ Previous splenectomy or functional asplenia
- □ Liver, lung or bone marrow transplant (circle which)
- □ Alcoholism
- □ Intravenous drug use
- □ Other chronic diseases, specify:
Nosocomial Influenza Cases

SIGNS AND SYMPTOMS

20) Specify Initial Symptoms:
☐ Feverishness
☐ Measured Fever (>=38 C)
☐ Cough
☐ Difficulty breathing/SOB
☐ Sore throat
☐ Runny nose, nasal congestion
☐ Abdominal pain
☐ Diarrhea
☐ Vomiting
☐ Headache
☐ Lethargy/Malaise
☐ Weakness
☐ Dizziness
☐ Muscle aches
☐ Seizures
☐ Other:

What triggered testing for influenza (from the medical chart)?
☐ New onset of respiratory illness  ☐ New fever  ☐ Outbreak workup  ☐ Other (specify)

COURSE OF ILLNESS after Influenza Onset

21)  ☐ Yes  ☐ No
Admitted to ICU due to influenza illness?
Date admitted: __________________ Date discharged: __________________

22)  ☐ Yes  ☐ No
Mechanically ventilated due to influenza illness?

23) Clinical Diagnoses (as per MD notes in chart, clinical consult reports, check as many as applicable):
☐ Influenza
☐ Bronchiolitis
☐ Asthma
☐ Otitis media
☐ Other lower resp tract infection (specify):
☐ Pneumonia, X-ray Confirmed? ☐ Yes ☐ No
☐ Exacerbation COPD (AECB)
☐ Sepsis
☐ Viral infection
☐ Other infection (specify):

☐ Other upper resp tract infection (specify):
☐ Other non-infectious diagnosis (specify):

24) Complications of influenza episode (check as many as applicable):  ☐ No complications

☐ Myocardial infarction
☐ Unstable angina
☐ Stroke (cerebrovascular accident)
☐ Seizures
☐ Acute renal failure requiring dialysis
☐ Fracture (specify which bone):
☐ Other complication (specify):

☐ New arrhythmia:
[☐ Episode of atrial fibrillation]
[☐ Other arrhythmia, specify __________________]
☐ C. difficile colitis
☐ Exacerbation of chronic disease process (specify)

25) Documented discharge diagnose(s) and disease(s) codes:

INFLUENZA TREATMENT IN THE HOSPITAL
26) **Yes**  [ ]  **No**  [ ]  In the hospital, were **antibiotics used to treat this episode**?

*If Yes, specify date/time administration of first antibiotic to treat this episode:*

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________________</td>
<td>______________________</td>
</tr>
</tbody>
</table>

Name of first antibiotic drug: __________________________

Specify name and dose of A/Bs used to treat this infection in the hospital: (use back of this page if required)

<table>
<thead>
<tr>
<th>ANTIBIOTIC</th>
<th>DOSE &amp; INTERVAL</th>
<th>START DATE</th>
<th>STOP DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

27) **Yes**  [ ]  **No**  [ ]  In the hospital, were **anti-influenza drugs used to treat this infection**?

*If Yes, specify (mark that apply) name, dose, interval and duration of anti-influenza drug.*

Specify Date/Time of administration of first dose of anti-influenza drug to treat this infection:

<table>
<thead>
<tr>
<th>ANTI-INFLUENZA DRUG</th>
<th>DOSE</th>
<th>INTERVAL</th>
<th>DURATION (IN DAYS)</th>
<th>DATE OF FIRST DOSE</th>
<th>TIME OF FIRST DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amantadine (Symmetrel)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oseltamivir (Tamiflu)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zanamivir (Relenza)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Nosocomial Influenza Cases

**TIBDN ID:** ____________

### DATE OF PATIENT CONSENT/INTERVIEW:

__________________________________________

### RISK ASSESSMENT

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unk</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td>Pregnant? (females only)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>If yes, specify gestational age at the time of influenza onset:</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td></td>
<td></td>
<td></td>
<td>Is the patient a current smoker?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>If yes, specify: packs per day or pack/yr</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td>Is the patient a Health Care Worker?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>If yes, specify occupation (e.g. RN, RT, paramedics):</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Type of institution or name of hospital/nursing home:</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td>Did the patient travel outside of Canada within 30 days prior to symptoms onset</td>
<td></td>
</tr>
<tr>
<td></td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>If yes, specify the destination (city, country):</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Specify the dates:</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td></td>
<td></td>
<td></td>
<td>Does child attend day-care?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>If Yes, specify the name and address:</td>
<td></td>
</tr>
</tbody>
</table>

### VACCINATION

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unk</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>33</td>
<td></td>
<td></td>
<td></td>
<td>Has patient ever received pneumococcal vaccine?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>If Yes specify:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Prevnar □ Pneumovax</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>First dose (dd/month/yyyy)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Second dose</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Third dose</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unk</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td></td>
<td></td>
<td></td>
<td>Did patient receive influenza vaccine in the fall/winter of 2005/6?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>Date of vaccine (if available):</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>If Yes, Location given:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Family MD office □ Public Health Clinic □ Pharmacy clinic □ Other, specify:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Date of vaccine (if available):</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td></td>
<td></td>
<td></td>
<td>Had the patient received influenza vaccine in previous years?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>If yes, mark the seasons when received:</td>
<td></td>
</tr>
</tbody>
</table>
Has the patient been receiving **any prescription** medications prior to the influenza episode?

List all medications the patient was receiving IN THE HOSPITAL **ONE day** prior to the onset of influenza symptoms (indicate antibiotics in Q37)

<table>
<thead>
<tr>
<th>ANTIBIOTIC</th>
<th>DOSE &amp; INTERVAL</th>
<th>INDICATION</th>
<th>START DATE</th>
<th>STOP DATE</th>
</tr>
</thead>
</table>

Had patient received antibiotics **in the three months prior** to this episode? **INCLUDING** ANTIBIOTICS RECEIVED DURING THIS HOSPITAL ADMISSION, BUT PRIOR TO INFLUENZA EPISODE

<table>
<thead>
<tr>
<th>Yes, patient was on regular antibiotics (e.g. prophylaxis for Otitis in winter mo)</th>
<th>ANTIBIOTIC</th>
<th>DOSE &amp; INTERVAL</th>
<th>INDICATION</th>
<th>START DATE</th>
<th>STOP DATE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Yes, patient was treated for infection</th>
<th>ANTIBIOTIC</th>
<th>DOSE &amp; INTERVAL</th>
<th>INDICATION</th>
<th>START DATE</th>
<th>STOP DATE</th>
</tr>
</thead>
</table>