TIBDN INFLUENZA SURVEILLANCE FORM

Hospital Acquired Influenza (v.1.2. Dec , 2005) TIBDN ID:_____ ___

1) Patient Initials _____	**2)** Sex: ☐ Male ☐ Female	**4)** Hospital:
3) DOB: _____ *(dd/month/yyyy)*		**5)** Postal code: _____

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 **<u>is >=48 hours after hospital admission</u>**
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/yyy)*

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
if culture done by PHL, specify PHL lab N:	
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

TIBDN ID : _____

17) Results of Cultures done within 3 DAYS (+/- 3) of test positive for Influenza (anything OTHER than influenza)

				If positive, Specify Organism	Date of the test
Blood	☐ not done	☐ Neg	☐ Pos		
CSF	☐ not done	☐ Neg	☐ Pos		
Pleural fluid	☐ not done	☐ Neg	☐ Pos		
Urine	☐ not done	☐ Neg	☐ Pos		
Throat swab	☐ not done	☐ Neg	☐ Pos		
Sputum	☐ not done	☐ Neg	☐ Pos		
Bronch. Specimen	☐ not done	☐ Neg	☐ Pos		
NP swab	☐ not done	☐ Neg	☐ Pos		
VRE/MRSA screen	☐ not done	☐ Neg		☐ VRE Pos ☐ MRSA 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**)

	Measurement	High Abnormal Range					Low Abnormal Range			
		+4	+3	+2	+1	0	+1	+2	+3	+4
Temperature (C)		>=41	39 - 40.9		38.5 - 38.9	36 - 38.4	34 - 35.9	32 - 33.9	30 - 31.9	<=29.9
Blood Pressure (Systolic /Diastolic)		Record most extreme BP; normal BP for adults usually fall in the range 90/60 – 130/80.								
Heart Rate		>=180	140 - 179	110 - 139		70 - 109	55 - 69	40 - 54		<=39
Respiratory Rate		>=50	35 - 49		25 - 34	12 - 24	10 - 11	6 – 9		<=5
Oxygenation:										
FiO2		(the higher – the worst) ; measured either in % or L/Min								
PaO2 (mmHg)		(the lower – the worst)				>70	61 - 70		55 - 60	<55
PaCO2 (mmHg)		Normal range – 35-45 mmHg (or 4.7-6.0 kPa)								
Arterial pH		>=7.7	7.6 - 7.69		7.5 - 7.59	7.33 - 7.49		7.25 - 7.32	7.15 - 7.24	<7.15
Serum HCO3 (venous mEq/L)		>=52	41 - 51.9		32 - 40.9	22 - 31.9		18 - 21.9	15 - 17.9	<15
Serum Sodium (mEq/l)		>=180	160 - 179	155 - 159	150 - 154	130 - 149		120 - 129	111 - 119	<=110
Serum Potassium (mEq/l)		>=7	6 - 6.9		5.5 - 5.9	3.5 - 5.4	3 - 3.4	2.5 - 2.9		<2.5
Serum Creatinine (mmol/l)		>=305	170-304	130-169		54-129		<54		
Hematocrit (%)		>=60		50 - 59.9	46 - 49.9	30 - 45.9		20 - 29.9		<20
White Blood Count (x 10^9/L)		>=40		20 - 39.9	15 - 19.9	3 - 14.9		1 – 2.9		<1
S_aO_2 (%) (0xygen Saturation)		(the lower – the worst)								

18A) Glasgow Coma Score (circle the corresponding score) ☐ Can not tell

Eye Opening:	Best Verbal Response:	Best Motor Response:
(1) None (2) To Pain (3) To Speech (4) Spontaneous	(1) None (2) Incomprehensible (3) Inappropriate Words (4) Confused (5) Oriented	(1) None (2) Abnormal Extension to Pain (3) Abnormal Flexion to Pain (4) Withdraws to Pain (5) Localized Pain (6) Obeys Commands

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19) PRIOR CHRONIC ILLNESS ☐ **None** **Yes** ☐ , if Yes circle All that apply:

ENDCOCRINE

- ☐ Diabetes mellitus with retinopathy, neuropathy or renal failure (creatinine >200)
- ☐ Diabetes mellitus, no complications

CARDIAC

- ☐ Angina *(chronic exertional angina; cases w/ coronary artery bypass graft; or cases w/unstable angina)*
- ☐ Arrhythmia (*w/chronic atrial fibrillation; sick sinus syndrome; ventricular arrhythmias requiring chronic treatment)*
- ☐ Valvular (*w/hemodynamically significant aortic or mitral stenosis or insufficiency; w/prosthetic aortic or mitral valves; mitral valve prolapse; asymmetric septal hypertrophy requiring treatment or tricuspid insufficiency)*
- ☐ Previous myocardial infarction (*cases that have history of definite or probable myocardial infraction, who have been hospitalized and had electrocardiographic or enzyme changes)*
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Other cardiac (specify)

VASCULAR

- ☐ 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):

PULMONARY

- ☐ Asthma
- ☐ COPD (Chronic Obstructive lung disease, Emphysema, Chronic Bronchitis)
- ☐ Other pulmonary (specify) :

If any pulmonary condition:

☐ Yes ☐ No Does the patient require constant oxygen supply?

If no, is the patient dyspneic?

- ❑ Yes, at rest
- ❑ Yes, at moderate activity
- ❑ No

RENAL

- ☐ Chronic renal failure (creatinine >200) *documented creatinine before influenza*: _____
- ☐ Nephrotic syndrome
- ☐ Kidney transplant
- ☐ Other renal (specify) _____

☐ Yes ☐ No Is the patient Dialysis dependent?

NEURO-MUSCULAR

- ☐ Dementia
- ☐ Cerebral palsy
- ☐ Hemiplegia or paraplegia
- ☐ Seizure disorder
- ☐ Spinal cord injury
- ☐ Chronic cerebrospinal fluid leak
- ☐ Amyotrophic disorder
- ☐ Other neuromuscular (specify)

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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)

GASTROINTENSTINAL

☐ Inflammatory bowel disease (*patients with ulcerative colitis or regional enteritis*)
☐ Peptic ulcer (*cases who have required treatment for ulcer disease, including those w/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, Waldensrorm', 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:

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SIGNS AND SYMPTIOMS

20) Specify Initial Symptoms:

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

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):
- ☐ Other upper resp tract infection (specify):
- ☐ Pneumonia, *X-ray Confirmed?* ❑ *Yes* ❑ *No*
- ☐ Exacerbation COPD (AECB)
- ☐ Sepsis
- ☐ Viral infection
- ☐ Fever
- ☐ Other 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

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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**:

Date : _____ Time: ___ _____

Name of first antibiotic drug: _____ dosage : _____

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

ANTIBIOTIC	DOSE& INTERVAL	START DATE	STOP DATE

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:

ANTI-INFLUENZA DRUG	DOSE	INTERVAL	DURATION (IN DAYS)	DATE OF FIRST DOSE	TIME OF FIRST DOSE
❑Amantadine (Symmetrel)					
❑Oseltamivir (Tamiflu)					
❑Zanamivir (Relenza)					

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 TIBDN ID : _____

DATE OF PATIENT CONSENT/INTERVIEW: _____

RISK ASSESSMENT

28) ☐ Yes ☐ No ☐ Unk — Pregnant? (females only)
If yes, specify gestational age in weeks at the time of inflenza onset: _____ weeks

29) ☐ Yes ☐ No ☐ Unk — Is the patient a current smoker?
If yes, specify: _____packs per day or _____pack/yr

30) ☐ Yes ☐ No ☐ Unk — Is the patient a Health Care Worker?

If yes, specify occupation (e.g. RN, RT, paramedics): _____

Type of institution or name of hospital/nursing home: _____

31) ☐ Yes ☐ No ☐ Unk — Did the patient travel outside of Canada within **30 days prior to symptoms onset**

If yes, specify the destination (city, country) _____

Specify the dates: _____

32) ☐ Yes ☐ No ☐ Unk
☐ Not applicable (>5 yrs old)
Does child attend day-care?
If Yes, specify the name and address:

VACCINATION

33) ☐ Yes ☐ No ☐ Unk — Has patient ever received **pneumococcal vaccine?**
If Yes specify : ☐ Prevnar ☐Pneumovax

First dose _____ *(dd/month/yyyy)*

Second dose _____

Third dose _____

34) ☐ Yes ☐ No ☐ Unk — Did patient receive **influenza vaccine in** the fall/winter of 2005/6?

Date of vaccine (*if available*): _____ *(dd/month/yyyy)*

If Yes, Location given:

❑ Family MD office ❑ Public Health Clinic ❑ Pharmacy clinic
❑ Other, specify:

35) ☐ Yes ☐ No ☐ Unk — Had the patient **received influenza vaccine** in **previous years**?

If yes, *mark the seasons when received:* ❑ (fall 2004) ❑ (fall 2003) ❑ (fall 2002) ❑ (fall 2001)

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MEDICATION HISTORY BEFORE THE EPISODE OF INFLUENZA ILLNESS

36) ☐ Yes ☐ No ☐ Unk 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)**

37) ☐ No ☐ Unk Had patient received antibiotics **in the three months prior** to this episode?
INCLUDING ANTIBIOTICS RECEIVED DURING THIS HOSPITAL ADMISSION, BUT PRIOR TO INFLUENZA EPISODE)

☐ Yes, patient was on regular antibiotics (e.g. prophylaxis for Otitis in winter mo):

ANTIBIOTIC	DOSE& INTERVAL	INDICATION	START DATE	STOP DATE

☐ Yes, patient was treated for infection:

ANTIBIOTIC	DOSE& INTERVAL	INDICATION	START DATE	STOP DATE

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