

North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

INFLUENZA, PEDIATRIC DEATH (< 18 YEARS OF AGE)
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 73

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name First Middle Suffix Maiden/Other Alias Birthdate (mm/dd/yyyy) SSN

NC EDSS LAB RESULTS

Verify if lab results for this event are in NC EDSS. If not present, enter results.

Table with 8 columns: Specimen Date, Specimen #, Specimen Source, Type of Test, Test Result(s), Description (comments), Result Date, Lab Name—City/State

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? If yes, symptom onset date (mm/dd/yyyy): CHECK ALL THAT APPLY: Fever, Shock, Encephalitis, Encephalopathy, Seizures / convulsions, Sore Throat, Bronchiolitis, Croup, Acute Respiratory Distress Syndrome (ARDS), Pneumonia, Bacteremia, Septicemia / sepsis, Reye Syndrome, Another viral co-infection, Was a specimen collected for bacterial culture from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid)?

Were other respiratory specimens collected for bacterial culture (e.g., sputum, ET tube aspirate)? Moderate to severe developmental delay, Diabetes, Cardiovascular/heart disease, Chronic lung disease (including asthma), Metabolic disorder, Pregnant, Hematologic disorder, History of febrile seizures, Seizure disorder, Kidney disease, Any immunosuppressive conditions, Neuromuscular disorder, Skin or soft tissue infection, Other underlying illness

Was the patient receiving any of the following therapies in the 7 days prior to illness onset or after illness onset? (check all that apply) Was the patient receiving any of the following therapies prior to illness onset? (check all that apply) Did the patient receive an antiviral for this illness? Specify antiviral name: Date antiviral treatment began: Number of days taken: Did the patient receive medical care for this illness? Specify level(s) of care (check all that apply): Did the patient require mechanical ventilation? Date started (mm/dd/yyyy): Number of days on mechanical ventilation:

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| | | | | | | |
|---------------------|-------|--------|--------|--------------|-------|-------------------------------|
| Patient's Last Name | First | Middle | Suffix | Maiden/Other | Alias | Birthdate (mm/dd/yyyy) / / |
| | | | | | | SSN / / |

NC EDSS PART 2 WIZARD (CONTINUED)
COMMUNICABLE DISEASE

Discharge/Final diagnosis: _____

Survived? Y N U

Died? Y N U

Died from this illness? Y N U

Date of death (mm/dd/yyyy): ____/____/____

Location of death:

Home

Emergency Department

Hospital ICU

Hospital inpatient

En route to hospital

Long-term care facility

Other, specify: _____

Unknown

Patient died in North Carolina? Y N U

County of death: _____

Died outside NC? Y N U

Specify where: _____

Autopsy performed? Y N U

Patient autopsied in NC? Y N U

County of autopsy: _____

Autopsied outside NC, specify where: _____

Source of death information (select all that apply):

Death certificate

Autopsy report final conclusions

Hospital/physician discharge summary

Other

Pathology specimens sent to CDC? Y N U

Did cardiac or respiratory arrest occur outside the hospital? Y N U

Did the patient receive any influenza vaccine during the current season (before illness)? Y N U

If yes, vaccine type:

Trivalent inactivated influenza vaccine (TIV) [injected]

Live-attenuated influenza vaccine (LAIV) [nasal spray]

Other, specify _____

Unknown vaccine type

How many doses did the patient receive and what was the timing of each dose?

1 dose ONLY

<14 days prior to illness onset

≥14 days prior to illness onset

Date dose given (mm/dd/yyyy): ____/____/____

2 doses

2nd dose given <14 days prior to illness onset

2nd dose given ≥14 days prior to illness onset

Date of 1st dose (mm/dd/yyyy): ____/____/____

Date of 2nd dose (mm/dd/yyyy): ____/____/____

Did the patient receive any influenza vaccine in previous seasons? Y N U

TREATMENT

Was antiviral prophylaxis given prior to illness onset? Y N U

If yes, specify: _____

Did the patient require supplemental oxygen? Y N U

Date started (mm/dd/yyyy): ____/____/____

Did the patient require high frequency oscillatory ventilation? Y N U

Date started (mm/dd/yyyy): ____/____/____

Did the patient require extracorporeal membrane oxygenation (ECMO)? Y N U

Date started (mm/dd/yyyy): ____/____/____

CLINICAL FINDINGS

Fatigue or malaise or weakness Y N U

Chills or rigors Y N U

Dehydration Y N U

Altered mental status Y N U

Coma Y N U

Meningitis Y N U

Muscle aches / pains (myalgias) Y N U

Myositis Y N U

Cough Y N U

Onset date (mm/dd/yyyy): ____/____/____

Apnea Y N U

Shortness of breath/difficulty breathing/respiratory distress Y N U

Did the patient have a chest x-ray? Y N U

If yes, describe (check all that apply)

Normal Pleural effusion

Infiltrate Other

Diffuse infiltrates/findings suggestive of ARDS

Cardiac arrhythmias or cardiac arrest Y N U

Myocarditis Y N U

Nausea Y N U

Vomiting Y N U

Abdominal pain or cramps Y N U

Diarrhea Y N U

Elevated liver enzymes Y N U

Leukopenia Y N U

Other symptoms, signs, clinical findings, or complications consistent with this illness Y N U

Please specify: _____

TRAVEL & IMMIGRATION

The patient is:

Resident of NC

Resident of another state or US territory

Foreign Visitor

Refugee

Recent Immigrant

Foreign Adoptee

None of the above

Did patient have a travel history during the 10 days prior to onset of symptoms? Y N U

List travel dates and destinations:

From ____/____/____ to ____/____/____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? Y N U

List persons and contact information:

Additional travel information: _____

OTHER EXPOSURE INFORMATION

Does the patient (or family) know anyone else with similar symptoms? Y N U

If yes, specify: _____

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? Y N U

1. Hospital name: _____

City, State: _____

Hospital contact name: _____

Telephone: (____) _____

Admit date ____/____/____

Discharge date ____/____/____

If applicable:

2. Hospital name: _____

City, State: _____

Hospital contact name: _____

Telephone: (____) _____

Admit date ____/____/____

Discharge date ____/____/____

CASE INTERVIEWS/INVESTIGATIONS

Were interviews conducted with others? Y N U

Who was interviewed? _____

Were health care providers consulted? Y N U

Who was consulted? _____

Medical records reviewed (including telephone review with provider/office staff)? Y N U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

In NC

City _____

County _____

Outside NC, but within US

City _____

State _____

County _____

Outside US

City _____

Country _____

Unknown

Is the patient part of an outbreak of this disease? Y N

Notes:

Influenza, pediatric death

2004 CDC Case Definition

Clinical description:

An influenza-associated death is defined for surveillance purposes as a death resulting from a clinically compatible illness that was confirmed to be influenza by an appropriate laboratory or rapid diagnostic test. There should be no period of complete recovery between the illness and death. Influenza-associated deaths in all persons aged <18 years should be reported.

A death should not be reported if:

1. There is no laboratory confirmation of influenza virus infection.
2. The influenza illness is followed by full recovery to baseline health status prior to death.
3. The death occurs in a person 18 years or older.
4. After review and consultation there is an alternative agreed upon cause of death.

Laboratory criteria for diagnosis

Laboratory testing for influenza virus infection may be done on pre- or post-mortem clinical specimens, and include identification of influenza A or B virus infections by a positive result by at least one of the following:

- Influenza virus isolation in tissue cell culture from respiratory specimens;
- Reverse-transcriptase polymerase chain reaction (RT-PCR) testing of respiratory specimens;
- Immunofluorescent antibody staining (direct or indirect) of respiratory specimens;
- Rapid influenza diagnostic testing of respiratory specimens;
- Immunohistochemical (IHC) staining for influenza viral antigens in respiratory tract tissue from autopsy specimens;
- Four-fold rise in influenza hemagglutination inhibition (HI) antibody titer in paired acute and convalescent sera*.

Case classification

Confirmed - A death meeting the clinical case definition that is laboratory confirmed.

Laboratory or rapid diagnostic test confirmation is required as part of the case definition; therefore, all reported deaths will be classified as confirmed.

Comment

*Serologic testing for influenza is available in a limited number of laboratories, and should only be considered as evidence of recent infection if a four-fold rise in influenza (HI) antibody titer is demonstrated in paired sera. Single serum samples are not interpretable.