**ATTENTION HEALTH CARE PROVIDERS:**
Please report relevant clinical findings about this disease event to the local health department.

**NC EDSS EVENT ID#**

**NC DISEASE CODE: 73**

**INFLUENZA, PEDIATRIC DEATH (< 18 YEARS OF AGE)**
Confidential Communicable Disease Report—Part 2

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.

---

**NC EDSS PART 2 WIZARD**
COMMUNICABLE DISEASE

**Is/was patient symptomatic for this disease?**
☐ Y ☐ N ☐ U

**If yes, symptom onset date (mm/dd/yyyy):** __/__/___

**CHECK ALL THAT APPLY:**

- Fever
- Temperature taken:
  - Orally
  - Rectally
  - Other
  - Unknown
- Fever onset date (mm/dd/yyyy): __/__/___
- Shock
- Encephalitis
- Encephalopathy
- Seizures / convulsions
- New onset
- Exacerbation of underlying seizure disorder
- Other
- Unknown
- Bronchiolitis
- Croup
- Acute Respiratory Distress Syndrome (ARDS)
- Pneumonia
- Confirmed by X-ray or CT scan?
- Bacteremia

**Date of positive blood culture:** __/__/___

**Septicemia / sepsis**

**Reye Syndrome**

**Another viral co-infection**

**Please specify:**

**Was a specimen collected for bacterial culture from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid)?**
☐ Y ☐ N ☐ U

If yes, please enter all positive results in the laboratory package.

---

**NC EDSS RESULTS**

**LAB RESULTS**

<table>
<thead>
<tr>
<th>Specimen Date</th>
<th>Specimen #</th>
<th>Specimen Source</th>
<th>Type of Test</th>
<th>Test Result(s)</th>
<th>Description (comments)</th>
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**NC EDSS PART 2 WIZARD**

**Communicable Disease**

**Were other respiratory specimens collected for bacterial culture (e.g., sputum, ET tube aspirate)?**
☐ Y ☐ N ☐ U

**If yes, please enter all positive results in the laboratory package.**

**Moderate to severe developmental delay**

**Diabetes**

**Cardiovascular/heart disease**

**If yes, specify:**

**Chronic lung disease (including asthma)**

**If yes, specify:**

**Metabolic disorder**

**If yes, specify:**

**Pregnant**

**If yes, specify:**

**Any immunosuppressive conditions**

**If yes, specify:**

**Neuromuscular disorder**

**If yes, specify:**

**Skin or soft tissue infection**

**If yes, specify:**

**Other underlying illness**

**If yes, specify:**

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)

- Aspirin or aspirin-containing products
- NSAID or NSAID-containing products

**Was the patient receiving any of the following therapies prior to illness onset?**

- Antiviral therapy (specify)
- Chemotherapy or radiation therapy
- Other immunosuppressive therapy (specify)

**Did the patient receive an antiviral for this illness?**

**Specify antiviral name:**

- Amantadine (Symmetrel)
- Oseltamivir (Tamiflu)
- Rimantadine (Flumadine)
- Zanamivir (Relenza)
- Other
- Unknown

**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):**

- Outpatient
- Urgent care
- Emergency department
- Other
- Inpatient

**Did the patient require mechanical ventilation?**

**CONTINUED NEXT PAGE**

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- Urgent care
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- Inpatient

**Did the patient require mechanical ventilation?**

**CONTINUED NEXT PAGE**

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

---

**NC EDSS PART 2 WIZARD**  
**COMMUNICABLE DISEASE**  
(CONTINUED)

**Discharge/Final diagnosis:**

Y ☐ N ☐ U

**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: ________________________________

**Patient died in North Carolina?**

Y ☐ N ☐ U

**County of death:**

Y ☐ N ☐ U

**Died outside NC?**

Y ☐ N ☐ U

**Specify where:**

Y ☐ N ☐ U

**Autopsy performed?**

Y ☐ N ☐ U

**Patient autopsied in NC?**

Y ☐ N ☐ U

**County of autopsy:**

Y ☐ N ☐ U

**Source of death information (select all that apply):**

☐ Death certificate  
☐ Autopsy report final conclusions  
☐ Hospital/physician discharge summary  
☐ Other, specify: ________________________________

**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 seasonal influenza vaccine during the current season (before illness)?**

Y ☐ N ☐ U

If yes, vaccine type:

☐ Inactivated influenza vaccine [injected]  
☐ Live-attenuated influenza vaccine (LAIV) [nasal spray]  
☐ Other, specify: ________________________________

**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 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): __/__/____

**Was the patient part of an outbreak of this disease?**

Y ☐ N ☐ U

---

**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

**Sore Throat**

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  
☐ Myocarditis  
☐ Nausea  
☐ Vomiting  
☐ Abdominal pain or cramps  
☐ Diarrhea  
☐ Elevated liver enzymes  
☐ Leukopenia  
☐ Other symptoms, signs, clinical findings, or complications consistent with this illness:

Y ☐ N ☐ U

Please specify:

---

**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):** __/__/____

---

**HOSPITALIZATION INFORMATION**

**Was patient hospitalized for this illness ≥24 hours?**

Y ☐ N ☐ U

**1. Hospital name:**

Y ☐ N ☐ U

**City, State:**

Y ☐ N ☐ U

**Hospital contact name:**

Y ☐ N ☐ U

**Telephone:** (______) _______ / _______

**Admit date __/__/____

**Discharge date __/__/____

**If applicable: 2. Hospital name:**

Y ☐ N ☐ U

**City, State:**

Y ☐ N ☐ U

**Hospital contact name:**

Y ☐ N ☐ U

**Telephone:** (______) _______ / _______

**Admit date __/__/____

**Discharge date __/__/____

---

**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:**

---

**OTHER EXPOSURE INFORMATION**

**Does the patient (or family) know anyone else with similar symptoms?**

Y ☐ N ☐ U

If yes, specify:

---

**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?**

☐ 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 ☐ U

---

DHHS/EPI #73  
JANUARY 2009  
Rev. 09/2009

INFLUENZA, PEDIATRIC DEATH (<18 YEARS OF AGE)  
PAGE 2 OF 3
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 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.