State of Connecticut
Department of Public Health
410 Capitol Ave., MS#11FDS
P.O. Box 0308
Hartford, CT 06134-0308
Phone: 860-509-7994 Fax: 860-509-7910

Hospitalized and Fatal Cases of Influenza – Case Report Form

Patient Information Date of Birth: _______________

Last Name: ______________________________ MI: ________ First Name: ______________________________

Street Address: _________________________________ City: _______________ State: _______ Zip code: ___________

Gender: ☐ Female ☐ Male ☐ Other: _____________ If female, pregnant? ☐ Yes ☐ No ☐ Unk. Due date: ______

Race: ☐ White ☐ Black/African Amer. ☐ Asian ☐ Native Amer./Alaska Native

☐ Nat. Hawaiian/Other Pacific Is. ☐ Other: ________________________

Ethnicity: Hispanic/Latino ☐ Yes ☐ No ☐ Unk.

Is the patient a Health Care Worker? ☐ Yes ☐ No ☐ Unknown work location: _____________

Is the patient a resident of a Longer Term Care Facility? ☐ Yes ☐ No ☐ Unknown name/location: ____________

Is the patient a College or University student? ☐ Yes ☐ No ☐ Unknown name location: _____________

Is the patient a Primary or Secondary School student? ☐ Yes ☐ No ☐ Unknown name location: _____________

Is the patient enrolled in a Day Care Center? ☐ Yes ☐ No ☐ Unknown name/location: ____________

Did patient recently return from international travel? ☐ Yes ☐ No ☐ Unknown location: ________________

Additional Information

Medical record number: ___________________________

Was case hospitalized? ☐ Yes ☐ No ☐ Unk.

Was case in an ICU/PICU? ☐ Yes ☐ No ☐ Unk.

Hospital name: _________________________________

Date of admission: ______________________________

Date of discharge: ______________________________

Physician name: ________________________________

Physician phone: _______________________________

Antiviral use (check all that apply)

☐ Oseltamivir (Tamiflu®) ☐ Zanamivir (Relenza®)

☐ Peramivir (Rapivab®) ☐ Baloxavir marboxil (Xofluza®)

Date treatment initiated: ______________

Received current season flu vaccine:

☐ Yes ☐ No ☐ Unknown

Did case die? ☐ Yes ☐ No ☐ Unknown

Date of death: __________________________________

Cause of death: _________________________________

Microbiologic Testing Check result for each test.

Test Method	Collection Date	Pos.	Neg.
☐ Rapid (antigen)	________________	☐	☐
☐ IFA/DFA	________________	☐	☐
☐ RT PCR (rapid or other)	________________	☐	☐
☐ Viral Culture	________________	☐	☐
☐ Other: ________________		☐	☐

Collection date: ___________________

Influenza type/subtype:

☐ Type A (H1N1) 2009

☐ Type A (H3N2) Seasonal

☐ Type A Unspecified

☐ Type B Seasonal

☐ Type Unknown

☐ Other flu type: ___________________________

☐ Other respiratory viruses: _____________________

Person completing form: _______________________ Phone number: _________________________