

***Important Note:***

**Regional and local health departments in Tennessee should not report cases directly to CDC. Immediate phone notification should be made to the Tennessee Immunization Program (TIP) at 800 404 3006 or 615 741 7247; completed case report forms should be faxed to TIP (615 741 3857).**

**Severe Illness (ICU Admission) or Death in Pregnant or Postpartum Woman  
Case Report  
Tennessee Department of Health**

**Use this form to report all pregnant and up to six weeks postpartum women with lab-confirmed influenza and who died.**

<b>Case ID:</b>	
<b>Medical record number:</b>	
<b>Contact name:</b>	
<b>Contact phone:</b>	
<b>Contact e-mail:</b>	
<b>Hospital name:</b>	
<b>Hospital zip code:</b>	
<b>Patient name:</b>	
<b>Patient DOB:</b>	
<b>State of residence:</b>	

**1. Patient Race (check all that apply):**

- White
- Black/African-American
- Asian/Pacific Islander
- American Indian/Alaskan Native
- Other
- Unknown

**2. Patient Ethnicity:**

- Hispanic
- Non-Hispanic
- Unknown

**3. Insurance Type:**

- Private health insurance
- Medicaid
- Self-pay
- Uninsured
- Unknown

**4. Notation in medical record of "high risk" pregnancy classification?**

- Yes  No  Unknown

**5. Underlying medical conditions/risk factors**

- None
- Asthma
- Other chronic lung disease
- Metabolic disorder (e.g. pre-existing diabetes, hyper or hypothyroidism)
- Gestational diabetes
- Obesity (prior to pregnancy)
- Cardiovascular disease, excluding hypertension
- Hypertension (prior to pregnancy)
- Gestational Hypertension/Preeclampsia/Eclampsia
- Neurological disorder including seizure disorder
- Tobacco use during current pregnancy
- Immunosuppression, specify \_\_\_\_\_
- Cancer diagnosed in last year
- Hematologic disorder (e.g. hemoglobinopathy)
- Hepatic disorder
- Substance abuse during current pregnancy (e.g. alcohol, illegal drug use)
- Psychiatric disorder
- Renal disease
- Other, specify: \_\_\_\_\_
- Unknown

**6.**

**Prenatal medications upon admission to hospital:**


7. Estimated due date? \_\_/\_\_/\_\_  Unknown

8. Gestational age at admission (wks): \_\_\_\_  Unknown

9. Was there fetal death?  Yes  No  Unknown

10. Date of symptom onset: \_\_/\_\_/\_\_  Unknown

11. Date initial care sought: \_\_/\_\_/\_\_  Unknown

12. Did mother receive rapid influenza test?  Yes  No  Unknown  
 Result of rapid test?  Positive  Negative  Unknown

13. Did mother receive rRT-PCR test?  Yes  No  Unknown  
 Result of rRT-PCR test?  Positive  Negative  Unknown

14. Did mother have any viral cultures?  Yes  No  Unknown  
 Result of viral cultures?  Positive  Negative  Unknown

15. Did mother receive DFA/IFA test?  Yes  No  Unknown  
 Result of DFA/IFA cultures?  Positive  Negative  Unknown

16. Did influenza testing confirm an influenza type or sub-type?  
 Yes - Flu A identified / Subtype identified (list subtype) \_\_\_\_\_  
 Yes - Flu A identified/ unknown Subtype  
 Yes - Flu B identified-  
 Yes - Flu C identified-  
 No flu type known

17. Did mother receive the current year's influenza vaccine more than 2 weeks before onset of illness?  Yes  No  Unknown

**18. Did mother take antiviral medications after becoming ill?**

Yes (list below)       No       Unknown

<input type="checkbox"/> Oseltamivir (Tamiflu®)	Dose _____ times/day Dates taken from ____/____/____ to ____/____/____
<input type="checkbox"/> Zanamivir (Relenza®)	Dose _____ times/day Dates taken from ____/____/____ to ____/____/____
<input type="checkbox"/> Rimantadine	Dose _____ times/day Dates taken from ____/____/____ to ____/____/____
<input type="checkbox"/> Amantadine	Dose _____ times/day Dates taken from ____/____/____ to ____/____/____
<input type="checkbox"/> IV Peramivir	Dose _____ times/day Dates taken from ____/____/____ to ____/____/____
<input type="checkbox"/> Other	Dose _____ times/day Dates taken from ____/____/____ to ____/____/____
<input type="checkbox"/> Unknown antiviral	

**19. Was the patient hospitalized for this illness?:**  Yes  No  Unknown

Hospital name and address: \_\_\_\_\_

**20. Date of hospital admission:** \_\_/\_\_/\_\_  Unknown

**21. Admitted to ICU?**  Yes  No  Unknown

**22. More than one ICU admission (e.g. transfer or readmission) for this illness?**

Yes  No  Unknown

**23. Date of initial ICU admission:** \_\_/\_\_/\_\_  Unknown

**24. More than one ICU admission (e.g. transfer/readmission) for this illness?:**

Yes  No  Unknown

**25. Total days in ICU** \_\_\_\_\_

Not yet discharged  Unknown

**26. Date of hospital discharge/death:** \_\_/\_\_/\_\_  Not yet discharged

**27. Maternal death?**  Yes  No  Unknown

**28. Other medications during hospitalization(s)**  None

- Antibiotics
- Antihypertensives
- Vasopressors
- Systemic corticosteroids. If yes, please specify reason (e.g. for maternal health or fetal lung maturity)

Nebulized drugs (e.g. albuterol)

Antiepileptics

Antiglycemics

Tocolytic agents

Diuretics

Narcotic Analgesic

Sedative/Hypnotic

Antifungal

Other, specify: \_\_\_\_\_

Unknown

**29. Was she diagnosed with:**

Pneumonia?  Yes, date: \_\_/\_\_/\_\_  No  Unknown

If pneumonia, check all known types/results of respiratory cultures

Culture type obtained	<b>Bacterial</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Viral</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Fungal</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Any positive result?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

List organisms identified if known \_\_\_\_\_  
\_\_\_\_\_

ARDS?  Yes, date: \_\_/\_\_/\_\_  No  Unknown

**30. Did she require mechanical ventilation?**

Yes, then how many days?\_\_  No  Unknown

Intubation start date: \_\_/\_\_/\_\_

Intubation end date: \_\_/\_\_/\_\_

*If there was a delivery, please complete questions 30-51. If not, skip to question 51*

**31. Date of delivery (or spontaneous/elective abortion):** \_\_/\_\_/\_\_

Unknown

**32. Delivery location:**

- Labor and delivery
- Emergency department
- Intensive care unit
- Other, specify: \_\_\_\_\_
- Unknown

**33. Method of delivery:**

- Undelivered
- Vaginal
- Cesarean, scheduled
- Cesarean, emergency
- Cesarean, unknown if emergency or scheduled
- Unknown

**34. Other delivery details/complications:**


**35. Outcome:**

- Live birth
- Stillbirth
- Spontaneous abortion
- Undelivered fetal demise
- Unknown

**36. Multiple gestation? (e.g. twins, triplets),**  Yes, Number\_\_  No  Unknown

NOTE: If multiple gestation pregnancy, copy, complete, and attach pages 4 and 5 of case report form for each infant

37. Gestational age at delivery (wks): \_\_\_\_\_
38. Infant birthweight: \_\_\_\_\_  Unknown
39. Infant 1-minute Apgar? \_\_\_\_\_  Unknown
40. Infant 5-minute Apgar? \_\_\_\_\_  Unknown
41. Infant to NICU?  Yes  No  Unknown
42. Date of NICU admission: \_\_/\_\_/\_\_  Unknown
43. Date of NICU discharge: \_\_/\_\_/\_\_  Not yet discharged  Unknown
44. Date of infant hospital discharge/death: \_\_/\_\_/\_\_  Unknown
45. Infant death?  Yes  No  Unknown

**46. Infant conditions during hospitalization**

- None
- Skin rash
- Fever
- Temperature instability
- Bradycardia
- Apnea
- Petechiae
- Chorioretinitis
- Cataracts
- Seizures
- Meningitis
- Other neurologic abnormality, specify: \_\_\_\_\_
- Hearing loss
- Pneumonia
- Sepsis
- Respiratory distress, specify cause: \_\_\_\_\_
- Hypoglycemia
- Hyperbilirubinemia/Jaundice (Etiology not specified)
- Hyperbilirubinemia/Jaundice R/T Prematurity
- Other, specify \_\_\_\_\_
- Unknown

47. Did infant receive rapid influenza test?  Yes  No  Unknown  
 Result of rapid test?  Positive  Negative  Unknown
48. Did infant receive rRT-PCR test?  Yes  No  Unknown  
 Result of rRT-PCR test?  Positive  Negative  Unknown
49. Did infant have any viral cultures?  Yes  No  Unknown  
 Result of viral cultures?  Positive  Negative  Unknown
50. Did infant receive DFA/IFA test?  Yes  No  Unknown  
 Result of DFA/IFA cultures?  Positive  Negative  Unknown

**51. Infant outcome (any details regarding isolation, antivirals, or complications):**


**52. Narrative (any relevant additional information on mother and/or infant):**
