



Pediatric COVID-19-Associated Mortality Case Report Form

This case report form should be completed for any patient who meets criteria for a respiratory syncytial virus-associated pediatric death defined as:

- Death in an individual <18 years of age resulting from an illness clinically compatible with COVID-19, AND
- There was no period of complete recovery between the COVID-19 illness and death, AND
- There is no alternative agreed-upon cause of death, AND
- Case meets confirmed or presumptive laboratory evidence for COVID-19*.

Completed case report forms should be sent via secure email to the local health department where the patient resides and the NJDOH Communicable Disease Service Respiratory team CDS.RESP@doh.nj.gov by the next business day.

*** COVID-19 Confirmatory Laboratory Evidence:**

Detection of SARS-CoV-2 nucleic acid in a clinical or post-mortem specimen using a diagnostic molecular test (e.g., NAAT) performed by a CLIA-certified provider, OR
Detection of SARS-CoV-2 RNA in a clinical or post-mortem specimen by genomic sequencing, OR
Detection of SARS-CoV-2 specific antigen by diagnostic immunocytochemistry staining performed by a CLIA-certified provider.

COVID-19 Presumptive Laboratory Evidence:

Detection of SARS-CoV-2 specific antigen in a clinical or post-mortem specimen using a diagnostic test performed by a CLIA-certified provider.

Pediatric COVID-19 Associated Mortality Case Report Form

STATE USE ONLY – DO NOT SEND INFORMATION *IN THIS SECTION* TO CDC

Last Name: _____ First Name: _____ County: _____
 Address: _____ City: _____ State, Zip: _____
 Site Use: _____ Medical Record or Other Identifier: _____

Reporter Information

1. Reporter Name	2. Case Classification: <input type="checkbox"/> Confirmed <input type="checkbox"/> Not Confirmed
3. Data Entry Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	3a. If yes, completed date: ____/____/____
4. Is this an eligible RESP-NET case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	4a. If yes, RESP-NET Case ID: _____

Demographic Information

5. State:	6. County:	7. State ID:	8. REDCap ID:
9. Date of birth: ____/____/____ MM DD YYYY	10. Age: ____ <input type="radio"/> Days (if <1 month) <input type="radio"/> Months (if < 1 year) <input type="radio"/> Years (if ≥ 1 year)	11a. Is sex known? <input type="radio"/> Yes <input type="radio"/> No 11b. Sex: <input type="radio"/> Male <input type="radio"/> Female	
12a. Is race and/or ethnicity known? <input type="radio"/> Yes <input type="radio"/> No			
12b. Race and/or ethnicity (Select all that apply)			
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic or Latino			

Death Information

13. Date of illness onset: ____/____/____ <input type="radio"/> Unknown MM DD YYYY
13a. Comments regarding onset date: _____
14. Date of death: ____/____/____ MM DD YYYY
15. Was an autopsy performed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
16. Location of death? <input type="radio"/> At home or in transit to hospital <input type="radio"/> Emergency Department (ED) <input type="radio"/> Inpatient Ward <input type="radio"/> ICU <input type="radio"/> Hospice Facility <input type="radio"/> Other: _____

Medical Care

17. Was this child seen at an outpatient healthcare facility (e.g., ED, clinic, other) within 14 days prior to death?

Yes No Unknown

17a. If yes, what was the most recent date of outpatient visit? ____/____/____
MM DD YYYY

18. Did cardiac/respiratory arrest occur outside the hospital? Yes No Unknown

19. Was there a hospital admission associated with this acute illness? Yes No Unknown

19a. If yes, what was the most recent date of admission? ____/____/____
MM DD YYYY

19b. Was the child admitted to an intensive care unit (PICU/ICU)? Yes No Unknown

19c. Was the child placed on mechanical ventilation? Yes No Unknown

SARS-CoV-2 Testing Results *(can add up to four clinical test results in database; start with most recent positive test associated with this acute illness)*

	Test Type	Test Result	Specimen Collection Date
20. Clinical Test 1	<input type="radio"/> Rapid Antigen Test <input type="radio"/> Molecular Assay (e.g., RT-PCR, RVP) <input type="radio"/> Method unknown/ Provider note only <input type="radio"/> Other, specify: _____	<input type="radio"/> Positive <input type="radio"/> Negative	____/____/____
21. Clinical Test 2	<input type="radio"/> Rapid Antigen Test <input type="radio"/> Molecular Assay (e.g., RT-PCR, RVP) <input type="radio"/> Method unknown/ Provider note only <input type="radio"/> Other, specify: _____	<input type="radio"/> Positive <input type="radio"/> Negative	____/____/____
22. Clinical Test 3	<input type="radio"/> Rapid Antigen Test <input type="radio"/> Molecular Assay (e.g., RT-PCR, RVP) <input type="radio"/> Method unknown/ Provider note only <input type="radio"/> Other, specify: _____	<input type="radio"/> Positive <input type="radio"/> Negative	____/____/____
23. Clinical Test 4	<input type="radio"/> Rapid Antigen Test <input type="radio"/> Molecular Assay (e.g., RT-PCR, RVP) <input type="radio"/> Method unknown/ Provider note only <input type="radio"/> Other, specify: _____	<input type="radio"/> Positive <input type="radio"/> Negative	____/____/____

24. Was there a positive result on a COVID-19 home test (e.g., a rapid antigen) associated with this acute illness? Yes No Unknown

24a. If yes, Date of test: Unknown OR ____/____/____ (if more than one, please record the date for the **first** known positive result).

25. Additional comments about test results (do not include identifiable information):

Additional Pathogen Testing (Potential Coinfections)

26. Was there a positive result for other viral respiratory pathogens associated with this acute illness? O Yes O No O Unknown

If "No" or "Unknown", skip to Question 27.

Please add other respiratory viruses detected from a respiratory specimen (e.g., NP, OP, throat, or nasal).

<u>Pathogen</u>	<u>Specimen Collection Date</u>
<input type="checkbox"/> Influenza A (subtype, if known: _____)	Date ____ / ____ / ____
<input type="checkbox"/> Influenza B (lineage, if known: _____)	Date ____ / ____ / ____
<input type="checkbox"/> Influenza (not specified)	Date ____ / ____ / ____
<input type="checkbox"/> Adenovirus	Date ____ / ____ / ____
<input type="checkbox"/> Common Human Coronavirus (229E, HKU1, NL63, OC43) (type, if known: _____)	Date ____ / ____ / ____
<input type="checkbox"/> Human Metapneumovirus	Date ____ / ____ / ____
<input type="checkbox"/> Parainfluenza (1,2,3,4) (type, if known: _____)	Date ____ / ____ / ____
<input type="checkbox"/> Rhino/Enterovirus	Date ____ / ____ / ____
<input type="checkbox"/> RSV	Date ____ / ____ / ____
<input type="checkbox"/> Other (_____)	Date ____ / ____ / ____

27. Please describe any other pathogens (bacterial/ fungal/ viral/ other) detected from a sterile (e.g., blood, cerebrospinal fluid (CSF), pleural fluid) or respiratory site (e.g., sputum, bronchoalveolar lavage (BAL), endotracheal aspirate, NP, OP, throat, or nasal). Specimens collected greater than 24 hours after death may represent contamination. Include date of collection & specimen type/site:

Pathogen Detected:	Collection Date:	Specimen type/site:	Comments:
_____	____ / ____ / ____	_____	_____
_____	____ / ____ / ____	_____	_____

Clinical Diagnoses and Complications

28. Did complications occur during the acute illness O Yes O No O Unknown

28a. If yes, check all complications that occurred during the acute illness:

- | | | |
|---|---|---|
| <input type="checkbox"/> <u>Cardiovascular</u>
<input type="checkbox"/> Acute Myocardial Infarction
<input type="checkbox"/> Acute Myocarditis
<input type="checkbox"/> Shock
<input type="checkbox"/> Vasculitis

<input type="checkbox"/> <u>Renal</u>
<input type="checkbox"/> Acute Renal Failure/ Acute Kidney Injury

<input type="checkbox"/> <u>Neurologic</u>
<input type="checkbox"/> Encephalopathy/ Encephalitis
<input type="checkbox"/> Seizures
<input type="checkbox"/> Stroke (CVA) | <input type="checkbox"/> <u>Respiratory</u>
<input type="checkbox"/> Acute Respiratory Distress Syndrome (ARDS)
<input type="checkbox"/> Acute Respiratory Failure
<input type="checkbox"/> Asthma exacerbation
<input type="checkbox"/> Bronchiolitis
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Croup
<input type="checkbox"/> Hemorrhagic Pneumonia/ pneumonitis
<input type="checkbox"/> Pneumonia

<input type="checkbox"/> <u>Endocrine</u>
<input type="checkbox"/> Diabetic Ketoacidosis (DKA) | <input type="checkbox"/> <u>Immunologic:</u>
<input type="checkbox"/> Autoimmune (Not MIS-C)
<input type="checkbox"/> Multisystem Inflammatory Syndrome in Children (MIS-C; for COVID-19 only)

<input type="checkbox"/> <u>Other</u>
<input type="checkbox"/> Pulmonary embolism (PE)/ Other thrombosis/ Embolism/ Coagulopathy
<input type="checkbox"/> Sepsis
<input type="checkbox"/> Other (specify):

_____ |
|---|---|---|

Pre-existing Conditions

29. Did the child have any medical conditions that existed before the start of the acute illness? Yes No Unknown

29a. If yes, check all medical conditions that existed before the start of the acute illness:

Cardiovascular Disease

Congenital heart disease

Other (specify) _____

Endocrine Disorder

Diabetes mellitus

Other (specify) _____

Gastrointestinal/Liver Disease

Specify: _____

Genetic and Developmental Conditions

Moderate to severe developmental delay

Chromosomal abnormality/ genetic syndrome

Mitochondrial Disorder (specify): _____

Other (specify) _____

Immunocompromised Conditions

Autoimmune conditions (specify) _____

Cancer (diagnosis and/or treatment began in previous 12 months) (specify): _____

Other (specify) _____

Neurologic Disorder

Cerebral Palsy

Neuromuscular disorder (e.g. muscular dystrophy) (specify): _____

Seizure disorder

History of febrile seizures

Other (specify) _____

Renal Disease

Specify: _____

Respiratory Disease

Asthma/ reactive airway disease

Cystic fibrosis

Chronic lung disease of prematurity/BPD

Other (specify) _____

Other

Hemoglobinopathy (e.g. sickle cell disease)

Obesity

Premature at birth (for cases <2 years of age) (specify gestational age): _____ weeks

Pregnant (specify gestational age): _____ weeks

Skin or soft tissue infection (SSTI)

Other (specify) _____

Medication and Therapy History

30. Did this child receive Paxlovid treatment for this acute illness? Yes No Unknown

COVID-19 Vaccine History

31. Does the child have documentation of a COVID-19 vaccine in the 12 months prior to death Yes No Unknown
If no or unknown, skip question 30 a-d.

31a. **COVID-19 vaccine doses received** (*For cases ≥ 6 months old, record up to 4 doses of COVID-19 vaccine received in the 12 months prior to death, beginning with the most recent*)

Dose Date

____/____/____
Month Day Year

Unk. Unk. Unk.

Dose Product

Pfizer-BioNTech COVID-19 Vaccine

Moderna COVID-19 Vaccine

Novavax COVID-19 Vaccine

Unknown

Other, specify _____

31b. **COVID-19 vaccine doses received** (*For cases ≥ 6 months old, record up to 4 doses of COVID-19 vaccine received in the 12 months prior to death, beginning with the most recent*)

Dose Date

____/____/____
Month Day Year

Unk. Unk. Unk.

Dose Product

Pfizer-BioNTech COVID-19 Vaccine

Moderna COVID-19 Vaccine

Novavax COVID-19 Vaccine

Unknown

Other, specify _____

31c. **COVID-19 vaccine doses received** (*For cases ≥ 6 months old, record up to 4 doses of COVID-19 vaccine received in the 12 months prior to death, beginning with the most recent*)

Dose Date

____/____/____
Month Day Year

Unk. Unk. Unk.

Dose Product

Pfizer-BioNTech COVID-19 Vaccine

Moderna COVID-19 Vaccine

Novavax COVID-19 Vaccine

Unknown

Other, specify _____

31d. **COVID-19 vaccine doses received** (*For cases ≥ 6 months old, record up to 4 doses of COVID-19 vaccine received in the 12 months prior to death, beginning with the most recent*)

Dose Date

____/____/____
Month Day Year

Unk. Unk. Unk.

Dose Product

Pfizer-BioNTech COVID-19 Vaccine

Moderna COVID-19 Vaccine

Novavax COVID-19 Vaccine

Unknown

Other, specify _____

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This section is optional. If you choose to complete this section, there is a separate form in REDCap to enter the data.

Addendum - Death Certificate Abstraction (Enhanced Data Collection)

Is information from the death certificate available? Yes No Unknown (If "No" or "Unknown", stop here.)

Patient Information – these fields are for linking/case ascertainment only and are not sent to CDC <i>(Use data from vital records or death certificate and clinical/autopsy/ME/other available data sources.)</i>		
1. First name:	2. Last name:	3. Local Identifier:
4. Zip code:	5. County of residence:	6. Date of birth (mm/dd/yyyy): ____ / ____ / ____
7. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	8. Date of positive COVID-19 test (mm/dd/yyyy): ____ / ____ / ____	9. Date of death (mm/dd/yyyy): ____ / ____ / ____
10. Clinical record matching comments (including inconsistencies, misspellings, other information needed for match):		
Death Certificate: Date and Time of Death		
1. Actual/presumed date of death: ____ / ____ / ____ <input type="checkbox"/> Unknown		
Death Certificate: Immediate and Underlying Causes of Death		
2a. Immediate Cause ICD Code:	3a. Free Text:	
2b. Underlying Cause ICD Code:	3b. Free Text:	
2c. Underlying Cause ICD Code:	3c. Free Text:	
2d. Underlying Cause ICD Code:	3d. Free Text:	
4. Other significant conditions contributing to death:		
1. _____	6. _____	
2. _____	7. _____	
3. _____	8. _____	
4. _____	9. _____	
5. _____	10. _____	
Additional Comments from Death Certificate (This field is sent to CDC – do not include identifiable information)		