Severe Illness (ICU Admission) or Death in Pregnant or Postpartum Woman
Case Report
Centers for Disease Control and Prevention

Instructions: Providers are encourage to report all ICU admissions and deaths among pregnant and postpartum (up to 6 weeks) women with a laboratory* confirmed influenza infection within 72 hours of diagnosis. Completed forms should be faxed to 609-826-5972. Alternatively, providers with access to the Communicable Disease Reporting and Surveillance System (CDRSS) may enter case information requested on the form into the appropriate fields of CDRSS.

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

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. Date of symptom onset: __/__/__ ☐ Unknown
10. Date initial care sought: __/__/__ ☐ Unknown

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

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

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

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

15. 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

16. Did mother receive any influenza vaccine in 2010 or 2011 more than 2 weeks before onset of illness? ☐ Yes ☐ No ☐ Unknown
If yes,2009 pandemic seasonal flu vaccine? ☐ Yes ☐ No ☐ Unknown
2009 pandemic H1N1 vaccine? ☐ Yes ☐ No ☐ Unknown

2010-2011 seasonal flu vaccine? ☐ Yes ☐ No ☐ Unknown

17. Did mother take antiviral medications after becoming ill?

☐ Yes (list below) ☐ No ☐ Unknown

□ Oseltamivir (Tamiflu®)	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Zanamivir (Relenza®)	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Rimantadine	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Amantadine	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ IV Peramivir	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Other	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Unknown antiviral	

18. Date of hospital admission: __/__/__ ☐ Unknown

19. Admitted to ICU? ☐ Yes ☐ No ☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

21. Date of initial ICU admission: __/__/__ ☐ Unknown

22. Total days in ICU_____

☐ Not yet discharged ☐ Unknown

23. Date of hospital discharge/death: __/__/__ ☐ Not yet discharged

24. Maternal death? ☐ Yes ☐ No ☐ Unknown

25. 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

26. Was she diagnosed with:

Pneumonia? ☐ Yes, date: __/__/__ ☐ No ☐ Unknown

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

Culture type obtained	**Bacterial** ☐ Yes ☐ No ☐ Unknown	**Viral** ☐ Yes ☐ No ☐ Unknown	**Fungal** ☐ Yes ☐ No ☐ Unknown
Any positive result?	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

List organisms identified if known_____
_____

ARDS? ☐ Yes, date: __/__/__ ☐ No ☐ Unknown

27. Did she require mechanical ventilation?
☐ Yes, then how many days?___ ☐ No ☐ Unknown
Date of intubation: __/__/__

28. Date of delivery (or spontaneous/elective abortion): ___/___/___
☐ Unknown

29. Delivery location:
☐ Labor and delivery
☐ Emergency department
☐ Intensive care unit
☐ Other, specify:_____
☐ Unknown

30. Method of delivery:
☐ Undelivered
☐ Vaginal
☐ Cesarean, scheduled
☐ Cesarean, emergency
☐ Cesarean, unknown if emergency or scheduled
☐ Unknown

31. Other delivery details/complications:

32. Outcome:
☐ Live birth
☐ Stillbirth
☐ Spontaneous abortion
☐ Undelivered fetal demise
☐ Unknown

33. 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

34. Gestational age at delivery (wks): ____
35. Infant birthweight: _____ ☐ Unknown
36. Infant 1-minute Apgar? ____ ☐ Unknown
37. Infant 5-minute Apgar? ____ ☐ Unknown
38. Infant to NICU? ☐ Yes ☐ No ☐ Unknown
39. Date of NICU admission: __/__/__ ☐ Unknown

40. Date of NICU discharge: __/__/__ ☐ Not yet discharged ☐ Unknown
41. Date of infant hospital discharge/death: __/__/__ ☐ Unknown
42. Infant death? ☐ Yes ☐ No ☐ Unknown

43. 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

44. Did infant receive rapid influenza test?	☐ Yes	☐ No	☐ Unknown
Result of rapid test?	☐ Positive	☐ Negative	☐ Unknown
45. Did infant receive rRT-PCR test?	☐ Yes	☐ No	☐ Unknown
Result of rRT-PCR test?	☐ Positive	☐ Negative	☐ Unknown
46. Did infant have any viral cultures?	☐ Yes	☐ No	☐ Unknown
Result of viral cultures?	☐ Positive	☐ Negative	☐ Unknown
47. Did infant receive DFA/IFA test?	☐ Yes	☐ No	☐ Unknown
Result of DFA/IFA cultures?	☐ Positive	☐ Negative	☐ Unknown

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

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