County of Los Angeles Public Health

INFLUENZA-ASSOCIATED DEATH CASE REPORT FORM

Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212, Los Angeles, CA 90012
213-240-7941 (phone) 213-482-4856 (facsimile)
publichealth.lacounty.gov/acd/

IRIS ID: _____

PATIENT DEMOGRAPHICS

Last name | First name | Middle initial | Date of birth

Street address | Apt #
☐ Homeless

City | State | Zip code
CA

Skilled nursing/Long-term care/Assisted living resident? ☐ Yes ☐ No ☐ Unknown

If yes, facility name

Occupation

Gender identity
☐ Female ☐ Male ☐ Refused/Unknown
☐ Transgender Female/Trans Woman
☐ Transgender Male/Trans Man
☐ Gender Non-Binary/Non-Conforming
☐ Other: _____

Sex at birth
☐ Female ☐ Male ☐ Non-Binary or X
☐ Refused/Unknown
☐ Other: _____

Race/ethnicity (all that apply)
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American
☐ Hispanic/Latinx/Spanish origin ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Refused/Unknown ☐ Other: _____

Sexual orientation
☐ Bisexual ☐ Gay or Lesbian
☐ Straight or Heterosexual
☐ Not sure ☐ Refused/Unknown
☐ Other: _____

ILLNESS HISTORY

Symptom onset date | Hospital admission date | Date of death | Location of death (e.g. home, hospital)

If hospitalized, hospital name | Medical record number

Autopsy performed? ☐ Yes ☐ No ☐ Unknown

Hospital diagnoses
☐ Pneumonia ☐ Sepsis/Septic shock
☐ ARDS ☐ Encephalitis/encephalopathy
☐ Respiratory failure ☐ AKI/Renal failure
☐ Heart failure
☐ Secondary infection, organism: _____
☐ Other: _____

Patient required:
☐ Intubation ☐ Vasopressors
☐ Hemodialysis due to illness?

Vaccinated this season? ☐ Yes ☐ No ☐ Unknown
Date vaccinated: _____

Received influenza antivirals? ☐ Yes ☐ No ☐ Unknown
☐ Oseltamivir ☐ Zanamivir ☐ Peramivir ☐ Baloxavir ☐ Other

Antiviral start date: _____ Antiviral end date: _____

MEDICAL HISTORY

☐ Cardiovascular disease
☐ Chronic Lung Disease (E.g. Asthma, COPD)
☐ Diabetes Mellitus
☐ Renal disease (E.g. CKD, ERSD)
☐ Liver disease
☐ Immunosuppression (e.g. cancer)
☐ Overweight or Obese: BMI_____ Height_____ ☐in/ ☐cm Weight_____ ☐lbs ☐kg
☐ Other conditions:

☐ Hemoglobinopathy (E.g. sickle cell disease)
☐ Genetic disorder (e.g. Downs)
☐ Pregnant If yes, specify # of weeks: _____
☐ Postpartum If yes, delivery date: _____
☐ Neurodevelopmental/ Neurologic disorder (e.g. cerebral palsy)
☐ Immunosuppressive medication (e.g. chemotherapy, steroids)

Laboratory (include laboratory slip with report)

Test type	Date collected	Source	Result			
☐ PCR/NAAT ☐ Rapid antigen ☐ IFA/DFA ☐ Viral Culture			**Influenza A:** **Influenza B:**	☐ (H1)pdm09 ☐ Yamagata	☐ (H3) ☐ Victoria	☐ Unk ☐ Unk
☐ PCR/NAAT ☐ Rapid antigen ☐ IFA/DFA ☐ Viral Culture			**Influenza A:** **Influenza B:**	☐ (H1)pdm09 ☐ Yamagata	☐ (H3) ☐ Victoria	☐ Unk ☐ Unk

Testing laboratory:

COVID test in prior 90 days? ☐ Yes, Positive (Date:_____) ☐ Yes, Negative ☐ Not done ☐ Unknown

Investigation

Name of reporter | Phone | Email | Date | Medical records reviewed? ☐ Yes ☐ No