State of California - Health and Human Services Agency

Clinicians should report to their **Local Health Jurisdiction**

California Department of Public Health

LHJs should fax this form to **(510) 620-3949**

Respiratory Syncytial Virus (RSV) Death Form (<5 years)

PATIENT DEMOGRAPHICS

Last Name	First Name	Middle Name	Suffix

DOB (mm/dd/yyyy)	Age	☐ Years ☐ Months ☐ Days

Address Number & Street – Residence	Apartment / Unit Number

City / Town	State	Zip Code

County of Residence	Country of Residence

Country of Birth	If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)

Home Telephone	Cellular Phone / Pager	Work / School Telephone

E-mail Address	Other Electronic Contact Information

Work / School Location	Work / School Contact

Gender

☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown

☐ Male ☐ Trans male/ transman ☐ Identity not listed ☐ Declined to answer

Medical Record Number	Patient's Parent/Guardian Name

Occupation Setting

Occupation

Primary Language

☐ English

☐ Spanish

☐ Other: _____

Ethnicity (check one)

☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

☐ Unknown

Race(s)

(check all that apply, race descriptions on last page)

The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

☐ American Indian or Alaska Native

☐ Asian (check all that apply, see list on last page)

- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Malaysian
- ☐ Pakistani
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Vietnamese
- ☐ Other: _____

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander (check all that apply, see list on last page)

- ☐ Native Hawaiian
- ☐ Fijian
- ☐ Guamanian
- ☐ Samoan
- ☐ Tongan
- ☐ Other: _____

☐ White

☐ Other: _____

☐ Unknown

ADDITIONAL PATIENT DEMOGRAPHICS

Sex Assigned at Birth

☐ Female ☐ Unknown

☐ Male ☐ Declined to answer

Sexual Orientation

☐ Heterosexual or straight ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer

☐ Gay, lesbian, or same-gender loving ☐ Orientation not listed ☐ Unknown

☐ Bisexual

The information requested on this form is required by the California Department of Public Health for purposes of identification and public health investigation.

REPORTING AGENCY INFORMATION

Reporting local health jurisdiction	*Name of reporter*	*Telephone number of reporter*

SIGNS, SYMPTOMS, COMPLICATIONS, AND MEDICAL INTERVENTIONS

Signs and Symptoms

Symptomatic ☐ Y ☐ N ☐ Unknown *Date of symptom onset* _____/_____/_____

☐ Apnea	☐ Diarrhea	☐ Hypothermia	☐ Shortness of breath/Respiratory distress
☐ Congested/Runny nose	☐ Ear ache/Ear infection	☐ Inability to eat/Poor feeding	☐ Sore throat
☐ Cough	☐ Fever/Chills	☐ Lethargy, less active or sleepy	☐ Tachypnea
☐ Cyanosis	Highest recorded temperature,	☐ Myalgia/Muscle aches	☐ Wheezing
☐ Decreased vocalization or stridor	if available _____	☐ Nausea/Vomiting	☐ Other, specify _____
☐ Dehydration		☐ Seizures	

Complications

☐ Acute respiratory distress syndrome (ARDS)	☐ Pneumonia	☐ Seizures
☐ Altered mental status	☐ Pulmonary hypertension	☐ Sepsis/Multi-organ failure
☐ Bronchiolitis	☐ Secondary bacterial infection	☐ Other, specify _____

Medical Interventions

☐ BiPAP	☐ CPAP	☐ Nitric oxide	☐ Supplemental O_2
☐ ECMO (Extracorporeal Membrane Oxygenation)	☐ Intravenous pressors	☐ Resuscitation/CPR	☐ Other (excluding intubation), specify_____

BIRTH HISTORY

☐ Check if not documented

Was patient premature (<37 weeks gestation)	☐ Y	☐ N	☐ U	Weeks gestation _____
Respiratory disease syndrome associated with prematurity	☐ Y	☐ N	☐ U	
Did patient require supplemental oxygen during birth hospitalization	☐ Y	☐ N	☐ U	
Did mother smoke while pregnant	☐ Y	☐ N	☐ U	

UNDERLYING MEDICAL CONDITIONS

Did the patient have any underlying medical conditions? ☐ Y ☐ N ☐ U

Asthma/Reactive airway disease	☐ Y	☐ N	☐ U	Abnormality of upper airway	☐ Y	☐ N	☐ U	Blood disorder	☐ Y	☐ N	☐ U
Cardiovascular disease	☐ Y	☐ N	☐ U	Chronic metabolic disease	☐ Y	☐ N	☐ U	Chronic lung disease	☐ Y	☐ N	☐ U
Weight at admission <11 lb (5 kg)	☐ Y	☐ N	☐ U	Gastrointestinal disease	☐ Y	☐ N	☐ U	Genetic disorder	☐ Y	☐ N	☐ U
Immunosuppressed	☐ Y	☐ N	☐ U	Immunosuppressive medications	☐ Y	☐ N	☐ U	Liver disease	☐ Y	☐ N	☐ U
Renal disease	☐ Y	☐ N	☐ U	Other conditions	☐ Y	☐ N	☐ U				

If yes for any of the above, please specify: _____

RSV PROPHYLAXIS

Nirsevimab (Beyfortus) within 6 months of death: ☐ Y ☐ N ☐ U

If yes, date of most recent dose: ___/___/_____

Palivizumab (Synagis) within 60 days of death: ☐ Y ☐ N ☐ U

If yes, date of most recent dose: ___/___/_____

For infants <6 months of age ONLY:

Did birthing parent receive an RSV vaccination while pregnant with this child? ☐ Y ☐ N ☐ U

If yes, date of RSV vaccination: ___/___/_____ Weeks gestation at time of receipt: _____

HOSPITALIZATION INFORMATION

Patient hospitalized ☐ Y ☐ N ☐ U Nights hospitalized _____

Hospital name	*City*	*State*	*Zip code*	*Telephone*

Admission date / /	*Discharge date* / /	*Admission diagnosis*	*Discharge diagnosis*

Patient in ICU ☐ Y ☐ N ☐ U ICU admission date ___/___/___ ICU discharge date ___/___/___

Patient intubated ☐ Y ☐ N ☐ U Intubation start date ___/___/___ Intubation end date ___/___/___

DEATH INFORMATION

Date of death _____/_____/_____

Location of death ☐ Home ☐ ED ☐ Hospital ☐ Other, specify _____

Was an autopsy performed? ☐ Y ☐ N ☐ U *Where was autopsy performed?* _____ Describe findings _____

LABORATORY INFORMATION

Radiographic and Lumbar Puncture Findings

Medical procedure performed ☐ Chest X-ray ☐ Chest CT ☐ Lumbar puncture ☐ Other, specify _____

Procedure date _____/_____/_____ Procedure result _____ Describe findings _____

RSV Testing

Specimen source _____

Test performed ☐ Rapid antigen test ☐ Fluorescent antibody ☐ PCR ☐ Serology ☐ Viral culture ☐ Other, specify _____

Where was testing performed? _____ Collection date ____/____/____

Result interpretation ☐ Positive ☐ Negative ☐ Indeterminate ☐ Specimen inadequate ☐ Pending

RSV type ☐ A ☐ B ☐ A&B ☐Unknown

Bacterial Pathogens

Bacterial pathogens detected within 3 weeks of death ☐Y ☐ N ☐ U

Specimen source _____ Collection date ____/____/____ Pathogen detected _____

Overall interpretation ☐ Community acquired ☐ Hospital acquired ☐ Colonization ☐ Contaminant

Other Viral Pathogens

Other viral pathogens detected within 2 weeks of death ☐ Y ☐ N ☐ U

Specimen source _____ Collection date ____/____/____ Pathogen detected _____

Overall interpretation ☐ Community acquired ☐ Hospital acquired ☐ Colonization ☐ Contaminant

NOTES

CASE DEFINITION

Confirmed

A death in a child who is <5 years of age with an illness clinically compatible with respiratory syncytial virus (RSV) (e.g., fever, cough, rhinorrhea, congestion, decreased appetite, sneezing, difficulty breathing, wheeze; in very young infants, irritability, decreased activity, and breathing difficulties may be the only symptoms of infection) with laboratory confirmed RSV infection (e.g., rapid antigen test, polymerase chain reaction (PCR), viral culture, serology, fluorescent antibody).

Probable

A death in a child who is <5 years of age with an illness clinically compatible with RSV, but laboratory testing is inconclusive or specimens were unavailable/unsuitable for testing.

Suspect

A death in a child who is <5 years of age under investigation for RSV.

NOTE: There should be no period of complete recovery between the illness and death. RSV-associated deaths in all children aged <5 years should be reported.

A death should not be reported if:

- The RSV illness is followed by full recovery to baseline health status prior to death
- The death occurs in a person 5 years or older
- After review and consultation there is an alternative agreed upon cause of death

RACE DESCRIPTIONS	
Race	**Description**
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

ASIAN GROUPS				
Bangladeshi	Filipino	Japanese	Maldivian	Sri Lankan
Bhutanese	Hmong	Korean	Nepalese	Taiwanese
Burmese	Indian	Laotian	Okinawan	Thai
Cambodian	Indonesian	Madagascar	Pakistani	Vietnamese
Chinese	Iwo Jiman	Malaysian	Singaporean	

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS				
Carolinian	Kiribati	Micronesian	Pohnpeain	Tahitian
Chamorro	Kosraean	Native Hawaiian	Polynesian	Tokelauan
Chuukese	Mariana Islander	New Hebrides	Saipanese	Tongan
Fijian	Marshallese	Palauan	Samoan	Yapese
Guamanian	Melanesian	Papua New Guinean	Solomon Islander	