For Section of EPI use only:
AKSTARS #_____
Fax to ASVL
(Fax: 907-474-4036)

Confidential Influenza-Associated Mortality Case Report Form
State of Alaska, Section of Epidemiology

PATIENT INFORMATION

Last name	*First name*	*Date of birth* / /
Street address	*City*	*Zip code*

Gender · Female · Male

Ethnicity · Hispanic · Non-Hispanic · Unknown

Race · White · Black · Native American · Asian/Pacific Islander · Other · Unknown

ONSET, HOSPITALIZATION AND DEATH INFORMATION

Date of onset of symptoms / /	*Hospitalized?* · Yes · No · Unknown	*If hospitalized, hospital name and location*
Date of hospital admission / /	*Date of hospital discharge* / /	
Date of death / /	*Location of death (i.e. home, ED-name of hospital ED, etc.)*	*If died, autopsy performed?* · Yes · No · Unknown

INFLUENZA LABORATORY TESTING INFORMATION (Please attach a copy of the test result, if available)

Date of specimen collection / /	*Specimen type (e.g. nasopharyngeal swabs, endotracheal aspirate, bronchoalveolar lavage)*

Influenza type and/or subtype _____ | *Where was testing performed?*

*Rapid test*_____ *PCR*_____

INFLUENZA VACCINATION HISTORY

Received seasonal influenza vaccine during the current season?
Yes · No · Unknown

If yes, date vaccinated:
/ / *Please specify the type of influenza vaccine received:* _____

CLINICAL COURSE

Received antiviral treatment? · Yes · No · Unknown	*Type of antiviral* · Oseltamivir · Zanamivir · Other *Specify other*: _____	
Date antiviral treatment started / /	*Date antiviral treatment ended* / /	*Intubated?* · Yes · No · Unknown

Complications
· Pneumonia · ARDS · Sepsis · Acute renal failure · Encephalitis/encephalopathy · Required vasopressor · Required hemodialysis
· Pulmonary embolus · Secondary bacterial infection *If yes, specify organism*: _____
· Other *Specify other*: _____

SIGNIFICANT PAST MEDICAL HISTORY

· Cardiac disease · Chronic pulmonary disorder · Immunosuppression (e.g. cancer) · Immunosuppressive medications (e.g. chemotherapy, steroids)
· Metabolic disorder (e.g. diabetes mellitus, renal) · Neurological disorder (e.g. cerebral palsy) · Hemoglobinopathy (e.g. sickle cell disease)
· Genetic disorder (e.g. Down syndrome) · Obesity *If obese*, BMI (if known):_____ Height:_____Weight: _____
· Pregnant *If pregnant*, estimated delivery date:_____/_____/_____
· Postpartum *If postpartum*, delivery date:_____/_____/_____ · Other conditions (e.g. hypertension, hyperlipidemia)

Reported By:_____ **Date Reported:**_____/_____/_____

Phone Number: _____

Fax reports to (907) 563-7868. This form is also available online at:
http://dhss.alaska.gov/dph/Epi/Pages/pubs/conditions/default.aspx

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To report Public Health Emergencies ***call (907) 269-8000 or after hours (800) 478-0084***

STATE of ALASKA
Department of Health and Social Services