SAMPLE EXTENDED DATA COLLECTION (Long Form)

Case ID:_____

Reporting and Follow-up Information

1. Date case was reported to the state health department _____/ _____/ _____ (mm/dd/yyyy)
2. Date case report form initiated _____/ _____/ _____ (mm/dd/yyyy)
3. Name of person completing form_____
4. Person reporting case to health department:

   Name and Position: _____

   Institution: _____ Street address: _____

   City: _____ State/Country: _____ Zip: _____

   Phone: _____ Pager: _____

   Fax: _____ Email: _____

5. Other epi/medical contacts (include health departments, clinicians, laboratorians, medical records staff)

	Name and Position	Contact numbers
a.		
b.		
c.		
d.		
e.		

6. Facilities where patient received medical care for current illness

	Hospital/ Clinic Name	Patient or Medical Record	Admission/ Visit Date
a.			_____/ _____/ _____
b.			_____/ _____/ _____
c.			_____/ _____/ _____
d.			_____/ _____/ _____
e.			_____/ _____/ _____

7. Patient and family contacts

	Name and Relationship to Patient	Contact numbers
a.		
b.		
c.		
d.		
e.		

8. Permission from physician to contact patient or patient's family ? ☐ Yes ☐ No
9. Permission from patient or patient's family to recontact for followup ? ☐ Yes ☐ No
10. Data sources used to complete form (Check all that apply) ☐ Physician interview ☐ Medical record review ☐ Patient/patient's family
11. Patient's current status:
    - ☐ Died
    - ☐ Hospitalized, in ICU
    - ☐ Hospitalized, on ward
    - ☐ Discharged to chronic care facility
    - ☐ Discharged home
    - ☐ Never hospitalized
12. Diagnoses: _____

Case ID:_____

Demographic Information

1. Patient Name First: _____ Last: _____
2. Age: _____ Years/ Months/ Days (Circle One)
3. Date of birth: (mm/dd/yyyy) _____/ _____/ _____
4. Sex: ☐ Male ☐ Female
5. Race: check one
   - ☐ White
   - ☐ Black/African American
   - ☐ Asian
   - ☐ Hawaiian/Pacific Islander
   - ☐ American Indian/Native Alaskan
   - ☐ Unknown
   - ☐ Other, specify: _____
6. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
7. Was the patient born in the United States? ☐ Yes ☐ No ☐ Unknown
   If NO, Country of birth: _____ Year emigrated to U.S. _____
8. Place of residence:
   Street address: _____
   City: _____ State: _____ Zip: _____
   County: _____ Country: _____
   Phone #: (_____) _____ - _____ Phone2 #: (_____) _____ - _____
9. Does patient live in an institutional setting?
   If YES, Name of facility: _____ ☐ Yes ☐ No ☐ Unknown
   Room number: _____
   Type of facility:
   - ☐ Nursing home/long-term care facility
   - ☐ Residential program/treatment facility
   - ☐ Shelter
   - ☐ Jail/prison
   - ☐ Other: _____
10. Date of illness onset: _____/ _____/ _____ (mm/dd/yyyy)
11. Was the patient evaluated by a physician for this illness? ☐ Yes ☐ No ☐ Unknown
12. Was the patient evaluated at an emergency room for this illness? ☐ Yes ☐ No ☐ Unknown
13. Was the patient hospitalized for this illness? ☐ Yes ☐ No ☐ Unknown
    If YES, Date first hospitalized _____/ _____/ _____ (mm/dd/yyyy)
14. If hospitalized, has the patient been discharged? ☐ Yes ☐ No ☐ Unknown
    If YES, Date discharged _____/ _____/ _____ (mm/dd/yyyy)

Occupation

In the ONE MONTH PRIOR to illness onset (unless otherwise noted), did the patient:

1. Work outside of the home? ☐ Yes ☐ No ☐ Unknown
   If YES, Occupation: _____
   Company name: _____
   Describe activities: _____
   If YES, In a healthcare setting (e.g doctor's office, hospital, nursing home, lab)? ☐ Yes ☐ No ☐ Unknown
2. Attend school or day care? ☐ Yes ☐ No ☐ Unknown
   If YES, Name of school or day care: _____
3. Have children in day care? ☐ Yes ☐ No ☐ Unknown
   If YES, Name of school or day care: _____

Case ID:_____

Exposures to Respiratory Illness

In the ONE MONTH PRIOR to illness onset (unless otherwise noted), did/was the patient:

1. Have contact with anyone with a respiratory illness? ☐ Yes ☐ No ☐ Unknown
   If YES, Type of contact (check all that apply): ☐ Household/Intimate ☐ Institutional setting ☐ Healthcare setting ☐ Other, specify: _____ ☐ Co-worker
   If YES, dates of exposure: First date: _____/ _____/ _____ Last date: _____/ _____/ _____
2. Admitted to the hospital for another illness/condition ? ☐ Yes ☐ No ☐ Unknown
   If YES, Date admitted: _____/ _____/ _____ Date discharged: _____/ _____/ _____
   Describe reason for hospitalization: _____

Travel History (within past 8 weeks)

1. Travel outside of the United States? ☐ Yes ☐ No ☐ Unknown
   If YES, List countries: _____
2. Travel within the U.S but outside of his/her home state? ☐ Yes ☐ No ☐ Unknown
   If YES, List states: _____

Recreational activities (within past 8 weeks)

1. Garden, excavate or work with soil? ☐ Yes ☐ No ☐ Unknown
2. Spent time in an infrequently used structure/space (e.g. attic or cabin)? ☐ Yes ☐ No ☐ Unknown
3. Perform construction or renovations? ☐ Yes ☐ No ☐ Unknown
4. Mow grass or hay? ☐ Yes ☐ No ☐ Unknown
5. Go hiking or camping? ☐ Yes ☐ No ☐ Unknown
6. Explore caves ? ☐ Yes ☐ No ☐ Unknown
7. Have water exposures (e.g. fishing, boating, swimming, hot tub)?
   If YES, Type of water: ☐ Pool ☐ Saltwater (e.g. ocean) ☐ Freshwater (e.g. lake, river, stream) ☐ Other:_____

Animal Exposures (within past 8 weeks)

1. Have animals living in his/her home (including pets)? ☐ Yes ☐ No ☐ Unknown
2. Receive an animal bite (including wild and domestic animals)? ☐ Yes ☐ No ☐ Unknown
3. Receive an insect bite (e.g. mosquito, tick, spider)? ☐ Yes ☐ No ☐ Unknown
4. Have close contact with rodents (e.g. rats, mice, squirrels, prairie dogs)? ☐ Yes ☐ No ☐ Unknown
5. Have close contact with rodent droppings or rodent nests? ☐ Yes ☐ No ☐ Unknown
6. Have close contact with birds (includes turkeys and chickens)? ☐ Yes ☐ No ☐ Unknown
7. Have close contact with bird droppings? ☐ Yes ☐ No ☐ Unknown
8. Have close contact with swine? ☐ Yes ☐ No ☐ Unknown
9. Go hunting or fishing? ☐ Yes ☐ No ☐ Unknown
10. Skin, dress, or eat wild game? ☐ Yes ☐ No ☐ Unknown
11. Spend time on a farm, rural area or petting zoo? ☐ Yes ☐ No ☐ Unknown
12. Perform or assist with an animal necropsy? ☐ Yes ☐ No ☐ Unknown
13. Have close contact with animals in any other setting? ☐ Yes ☐ No ☐ Unknown

If the patient answered YES to any of the above questions, list animal(s)/insect(s), and type of exposure

	Animal/Insect	Type of exposure:
a.	_____	_____
b.	_____	_____
c.	_____	_____
d.	_____	_____

Case ID:_____

Medications/Biologicals

In the ONE MONTH PRIOR to illness onset (unless otherwise noted), did/was the patient:

1. Receive any immunizations? ☐ Yes ☐ No ☐ Unknown
   If YES, List vaccines:_____
2. Receive an influenza vaccine THIS SEASON? ☐ Yes ☐ No ☐ Unknown
   If yes, date of last vaccination: ____/____/_____
3. Take any medications including prescription, over the counter, or herbal remedies? ☐ Yes ☐ No ☐ Unknown
   If YES, List medications:_____

Other exposures

1. Smoke cigarettes? ☐ Yes ☐ No ☐ Unknown
2. Work with any chemicals or toxins? ☐ Yes ☐ No ☐ Unknown
   If YES, Specify:_____
3. Have any other significant exposures? ☐ Yes ☐ No ☐ Unknown
   If YES, Describe:_____

Past Medical History

Prior to his/her recent illness, had the patient ever been diagnosed with any of the following conditions:

1. AIDS/HIV-positive? ☐ Yes ☐ No ☐ Unknown
2. Any other immune compromising conditions/medications (e.g. steroids, chemotherapy)? ☐ Yes ☐ No ☐ Unknown
   If YES, Condition/Medication(s): _____
3. Bone marrow or solid organ transplant? ☐ Yes ☐ No ☐ Unknown
4. Asplenia (no spleen)? ☐ Yes ☐ No ☐ Unknown
5. Autoimmune disease, such as lupus? ☐ Yes ☐ No ☐ Unknown
   If YES, Type of disease: _____
6. Cancer/ malignancy? ☐ Yes ☐ No ☐ Unknown
   If YES, Type of cancer: _____ Year diagnosed: _____
7. Indwelling catheter? ☐ Yes ☐ No ☐ Unknown
8. Chronic lung disease? ☐ Yes ☐ No ☐ Unknown
9. Asthma? ☐ Yes ☐ No ☐ Unknown
10. Active tuberculosis or positive PPD? ☐ Yes ☐ No ☐ Unknown
11. Heart disease? ☐ Yes ☐ No ☐ Unknown
12. High blood pressure (hypertension)? ☐ Yes ☐ No ☐ Unknown
13. Stroke? ☐ Yes ☐ No ☐ Unknown
14. Deep venous thrombosis or coagulopathy? ☐ Yes ☐ No ☐ Unknown
15. Sickle cell disease/thalassemia/hemoglobinopathy? ☐ Yes ☐ No ☐ Unknown
16. Diabetes mellitus? ☐ Yes ☐ No ☐ Unknown
17. Goiter or thyroid disease? ☐ Yes ☐ No ☐ Unknown
18. Renal insufficiency or failure? ☐ Yes ☐ No ☐ Unknown
    If YES, On dialysis ☐ Yes ☐ No ☐ Unknown
19. Chronic hepatitis or liver disease? ☐ Yes ☐ No ☐ Unknown
20. Any other significant conditions? ☐ Yes ☐ No ☐ Unknown
    If YES, Specify:_____

Case ID:_____

Review of Symptoms

As part of this illness, has the patient had any of the following symptoms:

				Date first noted: (mm/dd/yyyy)
1. Fever?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
2. Sweats?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
3. Chills/rigors?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
4. Cough?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
If YES, with sputum production?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
If YES, bloody sputum/ hemoptysis?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
5. Wheezing?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
6. Shortness of breath/difficulty breathing?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
7. Chest pain?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
8. Runny nose?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
9. Sore throat?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
10. Difficulty swallowing?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
11. Ear pain?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
12. Red or draining eyes?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
13. Muscle aches?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
14. Joint pain/swelling?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
15. Enlarged/swollen glands?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
16. Rash?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
17. Stiff neck?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
18. Seizures?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
19. Vomiting?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
If YES, with blood?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
20. Diarrhea?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
If YES, with blood?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
21. Dark or bloody urine?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
22. Yellow skin/eyes (jaundice)?	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____
23. Any other significant symptoms?	☐ Yes	☐ No	☐ Unknown	
If YES, Describe, including dates of onset:	☐ Yes	☐ No	☐ Unknown	_____/ _____/ _____

24. Date of symptom resolution: _____/ _____/ _____

Case ID:_____

Physical signs

As part of this illness, did the patient have any of the following signs on physical exam?

Date first noted: (mm/dd/yyyy)

1. Recorded temperature >38.0 C (100.4 F) ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____
   If YES, max temperature recorded _____ _____ . _____ C or F (circle one)
   First date max temperature was recorded _____/ _____/ _____
   Last date patient had a fever >38.0 C _____/ _____/ _____
2. Systolic blood pressure <90 mm Hg ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____
3. Room air oxygen saturation <95% ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____
4. Wheezes or rhonchi ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____
5. Rales or crackles ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____
6. Signs of respiratory distress ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____
7. Adult respiratory rate (RR) =>25 ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____
   (Child <5 years: RR > 40) ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____
   (Infant: RR > 50) ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____
8. Arrhythmia ☐ Yes ☐ No ☐ Unknown _____/ _____
9. Lymphadenopathy ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____

   If YES, check all location(s):

   ☐ Postauricular ☐ Axillary
   ☐ Submandibular ☐ Inguinal
   ☐ Cervical ☐ Mediastinal

10. Rash ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____

    If YES, check all types noted:

    ☐ Macules/papules ☐ Vesicles/bullae ☐ Eschar
    ☐ Morbilliform ☐ Ulcers/sores ☐ Erythroderma
    ☐ Petechiae/purpura ☐ Peeling/desquamation

    If YES, check all sites involved:

    ☐ Head/neck
    ☐ Trunk
    ☐ Extremities

11. Mucosal lesions ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____
12. Meningismus/ nuchal rigidity ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____
13. Seizures ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____
14. Altered mental status of >24h duration ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____

    If YES, level of consciousness (check all that apply)

    ☐ Confused ☐ Lethargic
    ☐ Disoriented ☐ Agitated
    ☐ Drowsy ☐ Comatose

15. Focal neurologic abnormality ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____

    If YES, describe:_____

16. Hepatosplenomegaly ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____
17. Jaundice/icterus ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____
18. Any other significant physical findings ☐ Yes ☐ No ☐ Unknown _____/ _____/ _____

    If YES, Describe, including dates first noted:_____

Case ID:_____

Imaging studies

At any point during this acute illness, did the patient receive any of the following imaging studies?

1. Chest x-ray or CT scan: ☐ Yes ☐ No ☐ Unknown

   If YES, Date first performed: _____/ _____/ _____ Overall impression: ☐ Normal ☐ Abnormal ☐ Unknown

   If abnormal findings, check all that apply:
   ☐ Single lobar infiltrate ☐ Pleural effusion ☐ Pneumomediastium ☐ Enlarged heart
   ☐ Multi-lobar infiltrate ☐ Hilar adenopathy ☐ Widened mediastinum ☐ Enlarged trachea
   ☐ Complete opacification ☐ Granuloma ☐ Pulmonary cavity or blebs ☐ Enlarged epiglottis
   ☐ Interstitial infiltrate ☐ Pneumothorax ☐ Empyema

   Check all alveolar spaces with any abnormality:
   ☐ Left upper lobe ☐ Left lower lobe ☐ Right middle lobe
   ☐ Left lingula ☐ Right upper lobe ☐ Right lower lobe

   Summarize findings:_____

2. Another chest x-ray or CT scan with significantly different findings: ☐ Yes ☐ No ☐ Unknown

   If YES, Date performed: _____/ _____/ _____ Overall impression: ☐ Normal ☐ Abnormal ☐ Unknown

   If abnormal findings, check all that apply:
   ☐ Single lobar infiltrate ☐ Pleural effusion ☐ Pneumomediastium ☐ Enlarged heart
   ☐ Multi-lobar infiltrate ☐ Hilar adenopathy ☐ Widened mediastinum ☐ Enlarged trachea
   ☐ Complete opacification ☐ Granuloma ☐ Pulmonary cavity or blebs ☐ Enlarged epiglottis
   ☐ Interstitial infiltrate ☐ Pneumothorax ☐ Empyema

   Check all alveolar spaces with any abnormality:
   ☐ Left upper lobe ☐ Left lower lobe ☐ Right middle lobe
   ☐ Left lingula ☐ Right upper lobe ☐ Right lower lobe

   Summarize findings:_____

3. Cardiac catheterization or echocardiogram: ☐ Yes ☐ No ☐ Unknown

   If YES, Date performed: _____/ _____/ _____

   Ejection fraction: _____ %

   Overall impression: ☐ Normal ☐ Abnormal ☐ Unknown

   Summarize findings:_____

4. Other imaging study: ☐ Yes ☐ No ☐ Unknown

   If YES, Type of imaging study:_____

   If YES, Date performed: _____/ _____/ _____

   Site imaged: ☐ Head ☐ Abdomen ☐ Other:_____
   ☐ Chest ☐ Pelvis

   Overall impression: ☐ Normal ☐ Abnormal ☐ Unknown

   Summarize findings:_____

Case ID:_____

Hematology and Serum Chemistries

For the following tests, please list the intial values and any additional values if results changed significantly:

	First recorded	Other significant values		
	Date 1: ___ /___ / _____	Date 2: ___ /___ / _____	Date 3: ___ /___ / _____	Date 4: ___ /___ / _____
White blood cell count (WBC)	_____ cells/mm^3	_____ cells/mm^3	_____ cells/mm^3	_____ cells/mm^3
Differential for WBC above:				
Neutrophils:	_____ %	_____ %	_____ %	_____ %
Bands:	_____ %	_____ %	_____ %	_____ %
Lymphocytes:	_____ %	_____ %	_____ %	_____ %
Eosinophils:	_____ %	_____ %	_____ %	_____ %
Hematocrit (Hct)	_____ %	_____ %	_____ %	_____ %
Platelets (Plt)	_____ $10^3/mm^3$	_____ $10^3/mm^3$	_____ $10^3/mm^3$	_____ $10^3/mm^3$
Prothrombin time (PT)	_____ sec	_____ sec	_____ sec	_____ sec
INR	_____	_____	_____	_____
Sodium (Na)	_____ mEq/L	_____ mEq/L	_____ mEq/L	_____ mEq/L
Potassium (K)	_____ mEq/L	_____ mEq/L	_____ mEq/L	_____ mEq/L
Chloride (Cl)	_____ mEq/L	_____ mEq/L	_____ mEq/L	_____ mEq/L
Bicarbonate (HCO_2)	_____ mEq/L	_____ mEq/L	_____ mEq/L	_____ mEq/L
Calcium	_____ mEq/L	_____ mEq/L	_____ mEq/L	_____ mEq/L
Creatinine	_____ mg/dL	_____ mg/dL	_____ mg/dL	_____ mg/dL
Blood urea nitrogen (BUN)	_____ mg/dL	_____ mg/dL	_____ mg/dL	_____ mg/dL
Glucose	_____ mg/dL	_____ mg/dL	_____ mg/dL	_____ mg/dL
SGPT/ALT	_____ U/L	_____ U/L	_____ U/L	_____ U/L
SGOT/AST	_____ U/L	_____ U/L	_____ U/L	_____ U/L
Total bilirubin	_____ mg/dL	_____ mg/dL	_____ mg/dL	_____ mg/dL
Serum ammonia	_____ mcg/dL	_____ mcg/dL	_____ mcg/dL	_____ mcg/dL
Alkaline phosphatase	_____ U/L	_____ U/L	_____ U/L	_____ U/L
Lactate dehydrogenase (LDH)	_____ U/L	_____ U/L	_____ U/L	_____ U/L
Lipase	_____ U/L	_____ U/L	_____ U/L	_____ U/L
Creatine kinase (CK or CPK)	_____ U/L	_____ U/L	_____ U/L	_____ U/L
C-Reactive protein (CRP)	_____ mg/dL	_____ mg/dL	_____ mg/dL	_____ mg/dL
Erythrocyte sed rate (ESR)	_____ mm/hr	_____ mm/hr	_____ mm/hr	_____ mm/hr
Albumin	_____ gl/dL	_____ gl/dL	_____ gl/dL	_____ gl/dL

Case ID:____________________

Medications and Blood Products

At any point during this acute illness, did the patient receive any of the following?

1. Antimicrobials (include antibacterial, antiviral, and antifungal agents): ☐ Yes ☐ No ☐ Unknown
2. Immune modulating, immune suppressive or anti-inflammatory agents (e.g steroids, azathioprine, methotrexate): ☐ Yes ☐ No ☐ Unknown
3. Any other medications after symptom onset, including acetaminophen, ibuprofen or other over the counter medications: ☐ Yes ☐ No ☐ Unknown

If YES to any of questions 1-3, please complete the following information for each agent received

Name of the agent	Date 1st received	Date last received	Route of administration
____________________	____/ ____/ ____	____/ ____/ ____	☐PO ☐IV ☐IM ☐Other
____________________	____/ ____/ ____	____/ ____/ ____	☐PO ☐IV ☐IM ☐Other
____________________	____/ ____/ ____	____/ ____/ ____	☐PO ☐IV ☐IM ☐Other
____________________	____/ ____/ ____	____/ ____/ ____	☐PO ☐IV ☐IM ☐Other
____________________	____/ ____/ ____	____/ ____/ ____	☐PO ☐IV ☐IM ☐Other
____________________	____/ ____/ ____	____/ ____/ ____	☐PO ☐IV ☐IM ☐Other

4. Blood products:

If YES, Check types of products received:

☐ Whole blood ☐ Platelets
☐ Immunoglobulins/IVIG ☐ Cryoprecipitate
☐ Fresh frozen plasma ☐ Packed red blood cells (pRBCs)

Date 1st received any blood product: ______/ ______/ ______

Severity and Outcomes of illness

At any time during the current illness, did the patient require or have?

1. Admission to intensive care unit: ☐ Yes ☐ No ☐ Unknown
   If YES, Date admitted: ______/ ______/ ______ Date discharged (if applicable): ______/ ______/ ______
2. Supplemental oxygen: ☐ Yes ☐ No ☐ Unknown
   If YES, Date started: ______/ ______/ ______ Date stopped: ______/ ______/ ______
3. Vasopressor medications (e.g. dopamine, epinephrine): ☐ Yes ☐ No ☐ Unknown
   If YES, Date started: ______/ ______/ ______ Date stopped: ______/ ______/ ______
4. Mechanical ventilation: ☐ Yes ☐ No ☐ Unknown
   If YES, Date started: ______/ ______/ ______ Date stopped: ______/ ______/ ______
5. Cardiopulmonary arrest: ☐ Yes ☐ No ☐ Unknown
   If YES, Date: ______/ ______/ ______
6. Did the patient die? ☐ Yes ☐ No ☐ Unknown
   If YES, Date: ______/ ______/ ______
7. If the patient died, was an autopsy performed? ☐ Yes ☐ No ☐ Unknown
   If YES, Date: ______/ ______/ ______

Summarize findings:____

____

____

____

Case ID:_____

Sterile Site Fluids

If any sterile site fluids were obtained, please note the following results

Specimen type*	Date collected	Protein (mg/dl)	Glucose (mg/dl)	RBCs (cells/mm^3)	WBCs (cells/mm^3)	Polys (%)	Lymphs (%)

**Specimen type: Bronchoalveolar lavage (BAL), cerebrospinal fluid (CSF), pericardial fluid, peritoneal fluid, pleural fluid, synovial fluid, urine*

Case ID: _____

Culture results

Specimen type*	Date	Culture type (Check one)			Result (Check one)		If positive:		
		Bacterial	Viral	Fungal	No growth	Positive	Organism 1	Organism 2	Organism 3

**Specimen type: Blood, bronchoalveolar lavage (BAL), cerebrospinal fluid (CSF), nasopharyngeal swab/aspirate,pericardial fluid, peritoneal fluid, pleural fluid, sputum,synovial fluid, tissue (specify site), throat/oropharyngeal swab, stool or urine*

Case ID:_____

Diagnostic Tests for Infectious Diseases

If any diagnostic tests for infectious diseases were performed (e.g. antibody tests/serology, antigen detection, PCR, special stains) complete below:

Specimen type*	Date	Test performed	Results	Interpretation (circle one)	Laboratory notes (if present)
				Positive Negative Indeterminate	
				Positive Negative Indeterminate	
				Positive Negative Indeterminate	
				Positive Negative Indeterminate	
				Positive Negative Indeterminate	
				Positive Negative Indeterminate	
				Positive Negative Indeterminate	
				Positive Negative Indeterminate	
				Positive Negative Indeterminate	
				Positive Negative Indeterminate	

**Specimen type: Blood, bronchoalveolar lavage (BAL), cerebrospinal fluid (CSF), nasopharyngeal swab/aspirate, pericardial fluid, peritoneal fluid, pleural fluid, acute serum, convalescent serum, paired sera, sputum, synovial fluid, tissue (specify site), throat/oropharyngeal swab, stool or urine*

Case ID:__________

Histopathology

Tissue Type*	Biopsy tissue?	Abnormal findings?	Findings Comments (Check all that apply)						Comments
	☐ Yes ☐ No	☐ Yes ☐ No		Inflammation		Edema		Granuloma	
				Hemorrhage		Fibrosis		Cirrhosis	
				Necrosis		Vasculitis		Organisms present	

Tissue Type*	Biopsy tissue?	Abnormal findings?	Findings Comments (Check all that apply)						Comments
	☐ Yes ☐ No	☐ Yes ☐ No		Inflammation		Edema		Granuloma	
				Hemorrhage		Fibrosis		Cirrhosis	
				Necrosis		Vasculitis		Organisms present	

Tissue Type*	Biopsy tissue?	Abnormal findings?	Findings Comments (Check all that apply)						Comments
	☐ Yes ☐ No	☐ Yes ☐ No		Inflammation		Edema		Granuloma	
				Hemorrhage		Fibrosis		Cirrhosis	
				Necrosis		Vasculitis		Organisms present	

Tissue Type*	Biopsy tissue?	Abnormal findings?	Findings Comments (Check all that apply)						Comments
	☐ Yes ☐ No	☐ Yes ☐ No		Inflammation		Edema		Granuloma	
				Hemorrhage		Fibrosis		Cirrhosis	
				Necrosis		Vasculitis		Organisms present	

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**Tissue type, ex: Adrenal, bone marrow, brain, spinal cord, heart, kidney, liver, lung, lymph node, muscle, skin, spleen, etc*