REMEMBER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

### NC EDSS PART 2 WIZARD

**COMMUNICABLE DISEASE**

**Is/was patient symptomatic for this disease?**

- If yes, symptom onset date (mm/dd/yyyy): __/__/____

**CHECK ALL THAT APPLY:**

- Fever: __/__/____
- Temperature taken: __/__/____
- Fever onset date (mm/dd/yyyy): __/__/____
- Shock: __/__/____
- Encephalitis: __/__/____
- Encephalopathy: __/__/____
- Seizures / convulsions: __/__/____
- New onset: __/__/____
- Exacerbation of underlying seizure disorder: __/__/____
- Other: __/__/____
- Unknown: __/__/____

**Acute Respiratory Distress Syndrome (ARDS):** __/__/____

**Pneumonia:** __/__/____

**Confirmed by X-ray or CT scan?** __/__/____

**Bacteremia:** __/__/____

**Date of positive blood culture:** __/__/____

**Septicemia / sepsis:** __/__/____

**Another viral co-infection:** __/__/____

**Specify:** __/__/____

**Was a specimen collected for bacterial culture from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid)?** __/__/____

**If yes, please enter all positive results in the laboratory package.**

**Were other respiratory specimens collected for bacterial culture (e.g., sputum, ET tube aspirate)?** __/__/____

**If yes, please enter all positive results in the laboratory package.**

**Moderate to severe developmental delay:** __/__/____

**Diabetes:** __/__/____

**Cardiovascular/heart disease:** __/__/____

**If yes, specify:** __/__/____

**Chronic lung disease (including asthma):** __/__/____

**If yes, specify:** __/__/____

**Metabolic disorder:** __/__/____

**If yes, specify:** __/__/____

**Pregnant:** __/__/____

**If yes, specify:** __/__/____

**Kidney disease:** __/__/____

**If yes, specify:** __/__/____

**Any immunosuppressive conditions:** __/__/____

**If yes, specify:** __/__/____

**Neuromuscular disorder:** __/__/____

**If yes, specify:** __/__/____

**Skin or soft tissue infection:** __/__/____

**If yes, specify:** __/__/____

**Other underlying illness:** __/__/____

**If yes, specify:** __/__/____

**Was the patient receiving any of the following therapies prior to illness onset?** (check all that apply)

- Antiviral therapy (specify)
- Chemotherapy or radiation therapy
- Steroids by mouth or injection
- Other immunosuppressive therapy (specify)

**Did the patient receive an antiviral for this illness?** __/__/____

**Specify antiviral name:** __/__/____

- Amantadine (Symmetrel)
- Oseltamivir (Tamiflu)
- Zanamivir (Relenza)
- Other: __/__/____
- Unknown: __/__/____

**Date antiviral treatment began:** __/__/____

**Number of days taken:** __/__/____

**Did the patient receive medical care for this illness?** __/__/____

**Specify level(s) of care (check all that apply):**

- Outpatient
- Emergency department
- Other
- Inpatient
- Unknown

**Did the patient require mechanical ventilation?** __/__/____

**Specify:** __/__/____

**Verify if lab results for this event are in NC EDSS. If not present, enter results.**

<table>
<thead>
<tr>
<th>Specimen Date</th>
<th>Specimen #</th>
<th>Specimen Source</th>
<th>Type of Test</th>
<th>Test Result(s)</th>
<th>Description (comments)</th>
<th>Result Date</th>
<th>Lab Name—City/State</th>
</tr>
</thead>
<tbody>
<tr>
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</table>
**NC EDSS PART 2 WIZARD (CONTINUED)**

**COMMUNICABLE DISEASE**

**Discharge/Final diagnosis:**
- [ ] Y
- [ ] N
- [ ] U

**Survived?**
- [ ] Y
- [ ] N
- [ ] U

**Died?**
- [ ] Y
- [ ] N
- [ ] U

**Date of death (mm/dd/yyyy):**
- [ ] / 
- [ ] /

**Location of death:**
- [ ] Home
- [ ] Emergency Department
- [ ] Hospital ICU
- [ ] Hospital inpatient
- [ ] En route to hospital
- [ ] Long-term care facility
- [ ] Other, specify:
- [ ] Other

**Patient died in North Carolina?**
- [ ] Y
- [ ] N
- [ ] U

**County of death:**
- [ ] Y
- [ ] N
- [ ] U

**Died outside NC?**
- [ ] Y
- [ ] N
- [ ] U

**Specify where:**
- [ ] Y
- [ ] N
- [ ] U

**Patient autopsied in NC?**
- [ ] Y
- [ ] N
- [ ] U

**County of autopsy:**
- [ ] Y
- [ ] N
- [ ] U

**Autopsy performed?**
- [ ] Y
- [ ] N
- [ ] U

**Pathology specimens sent to CDC?**
- [ ] Y
- [ ] N
- [ ] U

**Did cardiac or respiratory arrest occur outside the hospital?**
- [ ] Y
- [ ] N
- [ ] U

**Did the patient receive any seasonal influenza vaccine during the current season (before illness)?**
- [ ] Y
- [ ] N
- [ ] U

**If yes, vaccine type:**
- [ ] Inactivated influenza vaccine [injected]
- [ ] Live-attenuated influenza vaccine (LAIV) [nasal spray]
- [ ] Other, specify:
- [ ] Unknown vaccine type

**How many doses did the patient receive and what was the timing of each dose?**
- [ ] 1 dose
- [ ] 2 doses

**Date of 1st dose (mm/dd/yyyy):**
- [ ] / 
- [ ] /

**Date of 2nd dose (mm/dd/yyyy):**
- [ ] / 
- [ ] /

**Did the patient receive any pandemic H1N1 influenza vaccine during the current season (before illness)?**
- [ ] Y
- [ ] N
- [ ] U

**If yes, vaccine type:**
- [ ] Inactivated influenza vaccine [injected]
- [ ] Live-attenuated influenza vaccine (LAIV) [nasal spray]
- [ ] Other, specify:
- [ ] Unknown vaccine type

**How many doses did the patient receive and what was the timing of each dose?**
- [ ] 1 dose
- [ ] 2 doses

**Date of 1st dose (mm/dd/yyyy):**
- [ ] / 
- [ ] /

**Date of 2nd dose (mm/dd/yyyy):**
- [ ] / 
- [ ] /

**CLINICAL FINDINGS**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Y</th>
<th>N</th>
<th>U</th>
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</thead>
<tbody>
<tr>
<td>Fatigue or malaise or weakness</td>
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<td></td>
<td></td>
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<tr>
<td>Chills or rigors</td>
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<td></td>
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<tr>
<td>Dehydration</td>
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<td></td>
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<tr>
<td>Altered mental status</td>
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<td></td>
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<tr>
<td>Coma</td>
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</tr>
<tr>
<td>Meningitis</td>
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<tr>
<td>Muscle aches / pains (myalgias)</td>
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<tr>
<td>Myositis</td>
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<td></td>
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<tr>
<td>Sore Throat</td>
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<tr>
<td>Cough</td>
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<tr>
<td>Onset date (mm/dd/yyyy)</td>
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<tr>
<td>Apnea</td>
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<tr>
<td>Shortness of breath/difficulty breathing</td>
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<tr>
<td>respiratory distress</td>
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<tr>
<td>Did the patient have a chest x-ray?</td>
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<tr>
<td>If yes, describe (check all that apply)</td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

**CASE INTERVIEWS/INVESTIGATIONS**

**TREATMENT**

**Was antiviral prophylaxis given prior to illness onset?**
- [ ] Y
- [ ] N
- [ ] U

**If yes, specify:**
- [ ] Y
- [ ] N
- [ ] U

**Did the patient require supplemental oxygen?**
- [ ] Y
- [ ] N
- [ ] U

**Date started (mm/dd/yyyy):**
- [ ] / 
- [ ] /

**Did the patient require high frequency oscillatory ventilation?**
- [ ] Y
- [ ] N
- [ ] U

**Date started (mm/dd/yyyy):**
- [ ] / 
- [ ] /

**Did the patient require extracorporeal membrane oxygenation (ECMO)?**
- [ ] Y
- [ ] N
- [ ] U

**Date started (mm/dd/yyyy):**
- [ ] / 
- [ ] /

**HOSPITALIZATION INFORMATION**

**Was patient hospitalized for this illness >24 hours?**
- [ ] Y
- [ ] N
- [ ] U

**1. Hospital name:**
- [ ] Y
- [ ] N
- [ ] U

**City, State:**
- [ ] Y
- [ ] N
- [ ] U

**Hospital contact name:**
- [ ] Y
- [ ] N
- [ ] U

**Telephone:**
- [ ] Y
- [ ] N
- [ ] U

**Admit date**
- [ ] Y
- [ ] N
- [ ] U

**Discharge date**
- [ ] Y
- [ ] N
- [ ] U

**If applicable:**
- [ ] Y
- [ ] N
- [ ] U

**2. Hospital name:**
- [ ] Y
- [ ] N
- [ ] U

**City, State:**
- [ ] Y
- [ ] N
- [ ] U

**Hospital contact name:**
- [ ] Y
- [ ] N
- [ ] U

**Telephone:**
- [ ] Y
- [ ] N
- [ ] U

**Admit date**
- [ ] Y
- [ ] N
- [ ] U

**Discharge date**
- [ ] Y
- [ ] N
- [ ] U
Influenza, adult death
2009 Case Definition (North Carolina)

Clinical description:
An influenza-associated death is defined for surveillance purposes as a death resulting from a clinically compatible illness that was confirmed to be influenza (either seasonal or pandemic) by an appropriate laboratory or rapid diagnostic test. There should be no period of complete recovery between the illness and death.

Influenza-associated deaths in all persons aged <18 years should also be reported separately as "Influenza, Pediatric Death".

A death should not be reported if:
1. There is no laboratory confirmation of influenza virus infection.
2. The influenza illness is followed by full recovery to baseline health status prior to death.
3. After review and consultation there is an alternative agreed upon cause of death.

Laboratory criteria for diagnosis
Laboratory testing for influenza virus infection may be done on pre- or post-mortem clinical specimens, and include identification of influenza A virus (seasonal or pandemic) or influenza B virus infections by a positive result by at least one of the following:

- Influenza virus isolation in tissue cell culture from respiratory specimens;
- Reverse-transcriptase polymerase chain reaction (RT-PCR) testing of respiratory specimens;
- Immunofluorescent antibody staining (direct or indirect) of respiratory specimens;
- Rapid influenza diagnostic testing of respiratory specimens;
- Immunohistochemical (IHC) staining for influenza viral antigens in respiratory tract tissue from autopsy specimens;
- Four-fold rise in influenza hemagglutination inhibition (HI) antibody titer in paired acute and convalescent sera*.

Case classification
Confirmed - A death meeting the clinical case definition that is laboratory confirmed.
Laboratory or rapid diagnostic test confirmation is required as part of the case definition; therefore, all reported deaths will be classified as confirmed.

Comment
*Serologic testing for influenza is available in a limited number of laboratories, and should only be considered as evidence of recent infection if a four-fold rise in influenza (HI) antibody titer is demonstrated in paired sera. Single serum samples are not interpretable.