

**Instructions:** Please keep the Patient's full name, MRN and other details in your records.

1. Hospital Code:    -

2. PAEDS Database Record No (Flu): \_\_\_\_\_

#### SECTION A: CLINICIAN DETAILS

\*3. Admitting Doctor's Name: \_\_\_\_\_

\*4. Dr Contact Details: Address: \_\_\_\_\_ \*5. Phone: \_\_\_\_\_

\*6. Email: \_\_\_\_\_

7. Date questionnaire completed:   /   /

#### SECTION B: PATIENT DETAILS

\*8. First 2 letters of first Name:   \*9. First 2 letters of Surname:

\*10. Date of Birth:   /   /   \*11. Sex: ☐ M ☐ F \*12. Medical record number \_\_\_\_\_

\*13. Home address: \_\_\_\_\_

\*14. Postcode:     \*15. Family telephone number: \_\_\_\_\_

\*16. Country of Birth: Australia ☐ Other ☐ specify \_\_\_\_\_ ☐ Unknown

\*17. Ethnicity: \*Aboriginal ☐ \*Torres Strait Islander ☐ \*Both Aboriginal and Torres Strait Islander

Caucasian ☐ Asian ☐ Pacific Islander ☐ Middle Eastern ☐ African ☐ Other ☐ (specify) \_\_\_\_\_ ☐ Unknown

\*18. Does the child reside in an institution? Yes ☐ No ☐ Unknown ☐

\*18a. If yes, specify name of institution \_\_\_\_\_

19. Is there a smoker in the household? Yes ☐ No ☐ Unknown ☐

\*20. What is the child's current weight (kg)? \_\_\_\_\_ \*21. What is the child's height (cm)? \_\_\_\_\_

#### SECTION C: Laboratory confirmation of Influenza

\*22. Rapid Antigen test? ☐ Yes ☐ No ☐ Unknown

\*23. Where was swab taken? ☐ GP ☐ ED ☐ Flu-clinic ☐ Other, Specify \_\_\_\_\_ ☐ Unknown

\*24. Date swabs taken?   /   /

\*25. Influenza Results: ☐ Influenza A ☐ Influenza B ☐ Unknown ☐ Not answered

\*26. Date of result?   /   /   \*27. Name of Lab \_\_\_\_\_

\*28. Influenza A subtyping: ☐ H1N1 influenza 09 (swine)? ☐ H1 (human) ☐ H3 ☐ Unknown ☐ Not answered

\*29. Date of result?   /   /   \*30. Name of Lab \_\_\_\_\_

31. Which lab test(s) confirmed influenza infection? ☐ Direct Immunofluorescence ☐ PCR ☐ Culture

32. Did the child have proven Swine flu (Influenza A H1N1 09) infection at time of presentation? ☐ Yes ☐ No ☐ Unknown

33. Highest WCC: \_\_\_\_\_ 34. Highest CRP: \_\_\_\_\_

#### SECTION D: Presentation and History

\*35. Has the patient experienced symptoms of an influenza-like illness? ☐ Yes ☐ No ☐ Unknown

\*36. Was the symptom onset prior to hospital admission? ☐ Yes ☐ No ☐ Unknown

\*37. Date of onset of symptoms prior to hospitalization:   /   /

38. Which of the following symptoms were present prior to admission?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> *Cough  | <input type="checkbox"/> *Fever – documented $\geq 38$ | <input type="checkbox"/> *Fever by self report $\geq 38$ |
| <input type="checkbox"/> *Sore throat                                  | <input type="checkbox"/> *Dyspnoea / shortness breath  | <input type="checkbox"/> *Coryza / runny nose            |
| <input type="checkbox"/> *Malaise / lethargy / tiredness               | <input type="checkbox"/> *Myalgia / joint pains        | <input type="checkbox"/> *Rigors                         |
| <input type="checkbox"/> *Headache                                     | <input type="checkbox"/> *Diarrhoea                    | <input type="checkbox"/> *Vomiting                       |
| <input type="checkbox"/> Confusion / disorientation                    | <input type="checkbox"/> Seizure                       | <input type="checkbox"/> Loss of consciousness           |
| <input type="checkbox"/> Rash  | <input type="checkbox"/> Difficulty walking / weakness |  |
| <input type="checkbox"/> Neuromuscular disorder, please specify: _____ |  |  |

39. Does the child have previous history of Guillain-Barré syndrome? ☐ Yes ☐ No ☐ Unknown

**SECTION E: Underlying medical conditions**

40. Does the child have any of the following chronic medical conditions or risk factors? *(tick as many as apply)*

- ☐ Cystic fibrosis
- ☐ \* Asthma requiring preventative medicine
- ☐ \* Other Chronic lung disease, please specify .....
- ☐ \* Pregnancy
- ☐ \* Morbid Obesity (MI >40)
- ☐ \* Underlying heart disease. Please specify.....
- ☐ \* Diabetes. If yes, please specify:- insulin-requiring ☐ non-insulin requiring ☐
- ☐ \* Chronic metabolic Disease, please specify .....
- ☐ \* Chronic kidney disease / kidney failure. Please specify.....
- ☐ \* Chronic liver disease / liver failure. Please specify.....
- ☐ \* Haemoglobinopathy. Please specify.....
- ☐ \* Immunocompromised, If yes, primary immunodeficiency ☐ secondary immunodeficiency ☐
- Please specify (eg. HIV+ve, immunosuppressant drugs, treated for malignancy in the last 12 months) .....
- ☐ \* Chronic neurological disease. Please specify.....
- ☐ \* Obstructive sleep apnoea
- ☐ \* Current smoker
- ☐ \* Other disease or risk factor. Please specify.....

**Section F. Details of Hospital Admission (Note: a stay of >8 hours in ED or in Hospital = admission)**

- \*41. Was the child admitted to hospital or ED? ☐ Yes ☐ No If Yes, Date: / /
- \*42. When did the child first present to a hospital ED department? Date: / /
- \*43. Did the child have repeat presentations to an ED department? ☐ Yes ☐ No ☐ UK If yes, date(s)? / /
- \*44. Was the hospitalisation because of the Swine flu (H1N1 '09) virus? ☐ Yes ☐ No ☐ UK
- \*45. Was the child admitted to a high dependency unit? ☐ Yes ☐ No ☐ UK
- \*45a. If yes, name of unit? ..... \*45b. Date of Admission: / /
- \*46. Was the child discharged from a high dependency unit? ☐ Yes ☐ No ☐ UK \*46a. Date of discharge: / /
- \*47. Was the child admitted to ICU? ☐ Yes ☐ No ☐ UK
- \*47a. Name of unit? ..... \*47b. Date of Admission: / /
- \*48. Was the child discharged from ICU? ☐ Yes ☐ No ☐ UK \*48a. Date of discharge: / /
- \*49. Were intubation and mechanical ventilated required? ☐ Yes ☐ No ☐ UK \*49a. If yes, duration? .....days
- \*50. Is this considered to be a nosocomial (hospital acquired) infection? ☐ Yes ☐ No ☐ UK
51. Was the symptom onset more than 48 hours after hospital admission for another reason? ☐ Yes ☐ No ☐ UK
52. Was the symptom onset less than 7 days after discharge from a healthcare facility for another reason? ☐ Yes ☐ No ☐ UK
- 52a. If yes, please specify health care facility?.....
53. Which of the following complications were present during hospital admission? *(tick as many as apply)*

- ☐ \*Pneumonia (with X-ray abnormality)
- ☐ \*Other severe respiratory disease eg. Pneumonitis, ALI
- ☐ \*Pleural effusion
- ☐ \*Pneumothorax
- ☐ \*Adult respiratory distress syndrome
- ☐ Encephalitis / encephalopathy
- ☐ Seizure ☐ Stroke
- ☐ Myocarditis ☐ Pericarditis ☐ Cardiomyopathy
- ☐ Rhabdomyolysis
- ☐ Purpura fulminans ☐ Disseminated coagulopathy
- ☐ Transverse myelitis ☐ Polyneuritis ☐ Guillain-Barré syndrome
- ☐ Shock (requiring >40 ml/kg fluid resuscitation)
- ☐ Acute renal failure ☐ Reye's Syndrome
- ☐ Laboratory proven bacterial co-infection at a sterile site within 72 hours of admission?

If yes, specify organism .....

Site of isolation? ... ☐ Blood culture ☐ Pleural fluid ☐ Other (specify)

- ☐ Laboratory proven non-bacterial infection within 72 hours of admission?
- ☐ Viral e.g. RSV, Parainfluenza specify.....
- ☐ Mycoplasma

### SECTION G: Contacts

\*54. Within seven days of onset of symptoms, had the child traveled outside of Australia? ☐ Yes ☐ No ☐ Unknown

\*54a. If yes, where? .....

\*55. Prior to admission did the child have contact with a person with confirmed influenza? ☐ Yes ☐ No ☐ Unknown

\*55a. If yes, what was the date of contact? / /

\*55b. If yes, who was the contact person? (eg. Parent, sibling, school friend, other?) .....

\*55c. What was the age of the contact person?.....years

\*56. Has the child had close contact with farm animals? ☐ Pigs ☐ Birds/Poultry **If yes**, specify.....

### SECTION H: Treatment

During this illness had the child been treated with:

57. Paracetamol? ☐ Yes ☐ No ☐ UK

58. Aspirin ☐ Yes ☐ No ☐ UK

59. Non-steroidal anti-inflammatory medications e.g. Nurofen or Ibuprofen? ☐ Yes ☐ No ☐ UK

\*60. Was the child treated with ☐ Tamiflu ☐ Relenza ☐ Neither ☐ Unknown

60a. Date treatment commenced: / /  60b. Dose .....mg. 60c. Duration: .....days

61. Did the child receive antibiotic treatment? ☐ Yes ☐ No ☐ Unknown

### SECTION I: Vaccination history

62. Had the child been vaccinated against influenza this calendar year? ☐ Yes ☐ No ☐ Unknown **If yes**, when? Month / 2009

63. If the child is aged <9 years has he/she received two influenza vaccines in the last 12 months? ☐ Yes ☐ No ☐ Unknown

64. Had the child been vaccinated against influenza previously? ☐ Yes (record) ☐ Yes (no record) ☐ No ☐ Unknown

**64a. If yes**, when? Year(s) .....

65. Has the child been vaccinated against pneumococcus? ☐ Yes (record) ☐ Yes (no record) ☐ No ☐ Unknown

**65a. If yes**, number of doses?.....

66. Has the child been vaccinated against H. Influenzae type B? ☐ Yes (record) ☐ Yes (no record) ☐ No ☐ Unknown

**66a. If yes**, number of doses?.....

### SECTION J: Outcome

\*67. At the time of reporting, was the child ☐ Still in ICU ☐ Still hospitalized ☐ Discharged Alive ☐ Died

If discharged, a) date of discharge: / /

If died, a) date of death / /  \*b) Was influenza a contributing factor? ☐ Yes ☐ No ☐ UK

68. If died, was autopsy performed? ☐ Yes ☐ No ☐ Unknown

68a. If yes, where was autopsy performed? ..... 68b. Is report attached? ☐ Yes ☐ No

69. Were there any ongoing problems on discharge? ☐ Yes ☐ No ☐ Unknown **If yes**, specify.....

70. Were there any ongoing medical problems at 6 weeks after discharge? ☐ Yes ☐ No ☐ Unknown

**If yes**, please specify.....