# Influenza Associated Death Summary Form

(Proforma to be filled up for all type of Influenza confirmed patients who have died)

## I. Reported by:

Name of the hospital with address:

## II. Patient Identification Data:

1. Name:_____
2. Date of Birth (dd/mm/yy) ----/----/---- Age (in yrs): - -
3. Sex ☐ Male ☐ Female

*If Female*, was the patient pregnant? ☐ Yes (weeks pregnant) ☐☐ No ☐ Unknown

4. Residential status: ☐ Urban ☐ Rural, specify address with contact telephone no. (Mobile preferred) of family member

## III. Clinical Data (Please tick one or more than one symptoms/ailments the patient had)

1. Signs and symptoms with date of onset (dd/mm/yy) : ----/----/----

| | Duration (in days) | | Duration (in days) |
|---|---|---|---|
| ☐ Mild fever | ☐ | ☐ High grade fever | ☐ |
| ☐ Cough | ☐ | ☐ Breathlessness | ☐ |
| ☐ Headache& bodyache | ☐ | ☐ Chest pain | ☐ |
| ☐ Running of nose | ☐ | ☐ Fall in blood pressure | ☐ |
| ☐ Sore throat | ☐ | ☐ Sputum with blood | ☐ |
| ☐ Vomiting | ☐ | ☐ Any other, specify | ☐ |
| ☐ Diarrhoea | ☐ | | |

2. Did the patient had any high risk illness / predisposing condition

i) Cortisone therapy + Yes ☐ No ☐ Unknown ☐
Immunosuppressive therapy

ii) HIV +ve only Yes ☐ No ☐ Unknown ☐

iii) AIDS Yes ☐ No ☐ Unknown ☐

iv) Diabetes mellitus Yes ☐ Controlled ☐ Uncontrolled ☐ No ☐ Unknown ☐

v) Chronic Lung disease (specify with duration) _____

vi) Chronic Heart disease (specify with duration) _____

vii) Chronic Kidney disease (specify with duration) _____

viii) Chronic Liver disease (specify with duration) _____

ix) Cancer (specify with duration) _____

x) Blood disorders (specify with duration)_____

xi) Neurological disorders (specify with duration)_____

xii) Any other (specify with duration) _____

3. Diagnostic Findings (clinical) :

3.1. General tests:

Did the patient have any of the following tests?

☐ Chest X – ray If yes, ☐ Normal ☐ Abnormal ☐ Unknown

☐ Chest CT scan If yes, ☐ Normal ☐ Abnormal ☐ Unknown

If chest X – ray or chest CT scan result abnormal:

Was there evidence of pneumonia?

☐ Yes ☐ No ☐ Unknown

3.2. Influenza testing:

Date of collection of sample: ___//___//___

Date of declaration of result: ___//___//___

Name of the lab which conducted test:

Result:

4. Treatment details:

4.1. Previous treatment history

I. Oseltamivir with duration

II. Treatment for other symptoms

III. Name of the Hospitals/health facilities/private practitioner where treatment taken with dates

4.2. Treatment given in the hospital where patient died

I. Date of admission:____//__//__

II. Date of death: :____//__//____

III. Cause of Death:

| | |
|---|---|
| Disease or condition directly leading to death: | |
| Antecedent causes:<br>(Morbid conditions, if any, giving rise to the above cause) | |
| Other significant conditions:<br>(Contributing to death, but not related to the disease or condition causing it) | |

IV. Did the patient receive Oseltamivir?

a. If yes, complete table below:

| **Drug** | **Date initiated** | **Date discontinued** | **Dosage (if, known)** |
|---|---|---|---|
| Oseltamivir | | | |
| Zanamivir | | | |

V. Treatment for complications (details)

VI. Did the patient require mechanical ventilation? ☐ Yes ☐No ☐ Unknown

(Signature of Treating Doctor / Medical Superintendent)

Date: …….

***Note: Each suspected/confirmed death due to seasonal influenza should be investigated with this format. Death audit report to be submitted by District Surveillance Unit to the State Surveillance Unit for appropriate public health actions***.