COUNTY OF LOS ANGELES
DEPT. OF HEALTH SERVICES
PUBLIC HEALTH
Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212
Los Angeles, CA 90012
213-240-7941 (phone)
213-482-4856 (facsimile)
www.lapublichealth.org/acd

Pediatric Influenza Death Supplemental Form

To be completed in conjunction with the Pediatric Severe Influenza Case History Form

Patient Name- Last | First | Middle Initial | Date of birth

Date of Death | Was an autopsy performed? ☐ Yes ☐ No If Yes, please attach autopsy report, if available.

Location of death:

☐ Home ☐ Emergency Room ☐ Inpatient ward ☐ Intensive Care Unit ☐ Other: Specify. ______________________

DIAGNOSTIC TESTING

Influenza testing (Check all tests that were performed)	Specimen collection date	Results
☐ Commercial rapid antigen test		☐ Influenza A ☐ Influenza B ☐ Negative ☐ Influenza A/B (Not Distinguished)
☐ Viral culture		☐ Influenza A (Subtyping not done) ☐ Influenza B ☐ Negative ☐ Influenza A (Unable to subtype) ☐ Influenza A (H1) ☐ Influenza A (H3)
☐ Direct fluorescent antibody (DFA)		☐ Influenza A ☐ Influenza B ☐ Negative ☐ Influenza A/B
☐ Indirect fluorescent antibody (IFA)		☐ Influenza A ☐ Influenza B ☐ Negative ☐ Influenza A/B
☐ Enzyme immunoassay (EIA)		☐ Influenza A (Subtyping not done) ☐ Influenza B ☐ Negative ☐ Influenza A (Unable to subtype) ☐ Influenza A (H1) ☐ Influenza A (H3)
☐ RT-PCR		☐ Influenza A (Subtyping not done) ☐ Influenza B ☐ Negative ☐ Influenza A (Unable to subtype) ☐ Influenza A (H1) ☐ Influenza A (H3)
☐ Immunohistochemistry (IHC)		☐ Influenza A ☐ Influenza B ☐ Negative

Was an INVASIVE bacterial infection confirmed by culturing an organism from a specimen collected from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid)? ☐Yes ☐ No

If Yes, Specify below:

☐ *Streptococcus pneumoniae* ☐ *Staphylococcus aureus,* methicillin **sensitive** ☐ *Neisseria meningitidis (serogroup, if known):*_________

☐ *Haemophilus influenzae* type b ☐ *Staphylococcus aureus,* methicillin **resistant (MRSA)** ☐ Group A streptococcus: ______________

☐ *Haemophilus influenzae* not-type b ☐ *Staphylococcus aureus,* **sensitivity not done** ☐ Other invasive bacteria: ______________

CONTACT INFORMATION

Submitter Name	Facility	Date	Telephone number	Fax number
			( )	( )

To report a case, contact and fax this form to:
Los Angeles County Department of Health Services – Public Health
Acute Communicable Disease Control Phone 213-240-7941 Fax 213-482-4856