Patient Demographics

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ E-mail: _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

Reporting Facility

Facility Name:_____

Facility City: _____ Facility County: _____

Physician Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

GENERAL COMMENTS

_____

_____

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Enterovirus D68 (EV-D68) Patient Summary Form

To be completed for all patients for whom specimens are being submitted to CDC for EV-D68 typing. As soon as possible, please 1) notify and send completed form to your local/state health department, and 2) include a hard copy of the form along with the 50.34 form for specimen shipment.

Today's Date: _____ **Name of person filling in form:** _____

Phone: _____ **Email:** _____

Hospital / Health Care Facility Name: _____ **STATE:** _____ **COUNTY:** _____

Hospital ID: _____ **State ID:** _____

Specimen ID (as submitted on 50.34 form for specimen shipment):_____
If multiple specimens are submitted per patient, please include additional specimen IDs in table below

Patient Sex: ☐ M ☐F **Age**: _____ ☐Months ☐Years **Patient's State of Residence** _____

Race: ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐American Indian or Alaska Native ☐White (More than one box can be checked) **Ethnicity**: ☐Hispanic ☐Non-Hispanic

Date of symptom onset: _____

Symptoms (*mark all that apply*): ☐Fever / Highest recorded temperature _____ (°F / °C) ☐Chills ☐Cough ☐Wheezing ☐Sore throat ☐Runny nose ☐Shortness of breath / difficulty breathing ☐Tachypnea ☐Retractions ☐Cyanosis ☐ Vomiting ☐Diarrhea ☐Rash ☐Lethargy ☐Seizure ☐Other (describe): _____

Does the patient have any comorbid conditions? (*mark all that apply*): ☐None ☐Unknown ☐Asthma ☐Reactive airway disease ☐Bronchopulmonary dysplasia ☐Cardiac disease ☐Immunocompromised ☐Prematurity, if yes gestational age_____ ☐Other (describe): _____

Abnormal Chest radiograph ☐Yes ☐No ☐Unknown **Abnormal Chest CT** ☐Yes ☐No ☐Unknown

	Yes	No	Unknown
Is/Was the patient: Hypoxic (sat <93%) on room air?			
Treated with supplemental oxygen?			
Treated with bronchodilators?			
Treated with antibiotics?			
Hospitalized? If Yes, *admission date*: _____			
If Yes, was the patient admitted to the Intensive Care Unit (ICU)?			
If Yes was the patient placed on non-invasive ventilation (BiPAP/CPAP)			
If Yes, was the patient intubated?			
If Yes, was the patient placed on ECMO?			
Did the patient die? If Yes, *date of death*: _____			

General Pathogen Laboratory Testing (*mark all that apply*)

Pathogen	Pos	Neg	Pending	Not Done	Pathogen	Pos	Neg	Pending	Not Done
Influenza A PCR					Rhinovirus and/or Enterovirus				
Influenza B PCR					Coronavirus (not MERS-CoV)				
Influenza Rapid Test					*Chlamydophila pneumoniae*				
RSV					*Mycoplasma pneumoniae*				
Human metapneumovirus					*Legionella pneumophila*				
Parainfluenzavirus					*Streptococcus pneumoniae*				
Adenovirus					Blood culture ☐Yes ☐No If positive, which bacteria_____				
Other: _____					CSF culture ☐Yes ☐No If positive, which bacteria_____				
Other: _____					Sputum culture ☐Yes ☐No If positive, which bacteria_____				

Enterovirus Typing - Specimen Type	Date Collected	Specimen ID	Enterovirus Typing - Specimen Type	Date Collected	Specimen ID
NP OP NP/OP (*circle one*)			Bronchoalvelolar lavage (BAL)		
Nasal wash / aspirate			Tracheal Aspirate		
Sputum			Stool/Rectal swab		
Other: _____			Other: _____		

To be completed by CDC: ***Patient ID:*** _____ ***CSID:*** _____ ***CSID:*** _____

CSID: _____ ***CSID:*** _____ ***CSID:*** _____