Utah Department of Health
Office of Epidemiology
288 North 1460 West
P.O. Box 142104
Salt Lake City, UT 84114
(801) 538 - 6191

Influenza Morbidity Report Form For Hospitalized Cases

Please fill in each blank or check the appropriate answer for each question.
(PLEASE PRINT)

Promote Prevent Protect
Utah Department of Health

PATIENT INFORMATION / DEMOGRAPHICS

Patient Name

Street | County

City | Zip Code

Date of Birth (MM/DD/YYYY)

Home Phone | Gender: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other:_____

Race: ☐ White ☐ Black ☐ Native American/Alaskan ☐ Pacific Islander ☐ Asian ☐ Other:_____

CLINICAL OUTCOMES

Name of Hospital | Date Admitted

Date of onset of Illness

Patient's Hospital ID Number | Did the patient die? ☐ Yes ☐ No ☐ Unknown

Was the illness for which this patient was hospitalized clinically compatible with influenza? ☐ Yes ☐ No ☐ Unknown

LABORATORY INFORMATION

Date of Lab Test | Test Method: ☐ PCR ☐ Culture ☐ DFA ☐ Rapid ☐ Other:_____

Lab Results: ☐ Influenza A ☐ Influenza B ☐ Influenza type not specified

*A viral influenza culture is recommended for hospitalized cases *

VACCINATION INFORMATION

Did the patient receive an influenza vaccine during the 2005 - 2006 influenza season? ☐ Yes ☐ No ☐ Unknown

HIGH RISK CATEGORIES

Did the patient travel out of the country during the 10 days before the onset of illness? ☐ Yes ☐ No ☐ Unknown
If yes, where and when?_____

Is the patient a healthcare worker with direct patient contact? ☐ Yes ☐ No ☐ Unknown

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown

Does the patient have a chronic heart, kidney, or metabolic disorder (i.e., diabetes, CAD, etc.)? ☐ Yes ☐ No ☐ Unknown

Does the patient have a chronic respiratory disorder (i.e., asthma, COPD, etc.)? ☐ Yes ☐ No ☐ Unknown

Is the patient immunosuppressed (due to HIV, cancer, etc.)? ☐ Yes ☐ No ☐ Unknown

REPORTED BY

Name/Facility | Phone Number | Date

Please Fax Completed Form To (801) 538 - 9923