U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
AND PREVENTION
ATLANTA, GA 30333

RSV-Associated Mortality Case Report Form

Part 1 - Chart Review

REDCap Record ID: ____ ____ ____ | **NNDSS Record ID:** _____ | **Mortality Case ID:** ____ ____ ____ ____ ____

A. Patient Data – THIS INFORMATION IS NOT SENT TO CDC

Last Name:	First Name:	Middle Name:	Chart Number:
Address:			
City:	State:	Zip Code:	
Site Use:			

B. Abstractor Information

1. Abstractor Name: | 2. Date of Abstraction: _____ / _____ / _____

C. Enrollment Information

1. Level of Care:
- ☐ Hospitalized
- ☐ ED/ER only
- ☐ Clinic/Outpatient only
- ☐ None
- ☐ Unknown

2. County:

3. State:

4. Date of Birth: _____ / _____ / _____

5. Date of Death: _____ / _____ / _____

6. Age: _____
- ☐ Years
- ☐ Months (if < 1 yr)
- ☐ Days (if < 1 month)

7. Sex:
- ☐ Male
- ☐ Female

8. Race:
- ☐ White
- ☐ Black or African American
- ☐ Asian/Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Multiracial
- ☐ Not specified

9. Ethnicity
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Not Specified

10. Type of Insurance (check all that apply):
- ☐ Private
- ☐ Medicare
- ☐ Medicaid/state assistance program
- ☐ Military
- ☐ Indian Health Service
- ☐ Incarcerated
- ☐ Uninsured
- ☐ Unknown
- ☐ Other, specify: _____

11. Pregnant? (15-49 years of age only):
- ☐ Yes
- ☐ No/Unknown
- ☐ Not applicable (male)

12. Hospital/ED Where Patient Treated: _____

12a. Admission/Visit Date: _____ / _____ / _____

12b. Discharge Date: _____ / _____ / _____

13. Was patient transferred from another hospital? ☐ Yes ☐ No ☐ Unknown

13a. Transfer Hospital: _____

13b. Transfer Hospital Admission Date: _____ / _____ / _____

13c. Transfer Date: _____ / _____ / _____

14. Location of Death: ☐ Inpatient Hospital ☐ ED/ER or Outpatient Setting ☐ Dead on Arrival ☐ Hospice Facility ☐ Long Term Care Facility ☐ Decedent's Home ☐ Unknown ☐ Other

If other, specify: _____

15. Was an autopsy performed? ☐ Yes ☐ No ☐ Unknown

(If yes): **15a. At which facility?** _____

15b. Cause of death findings: _____

D. RSV Testing Results

1. Test 1: ☐ Antigen ☐ Molecular Assay ☐ Viral Culture ☐ Serology ☐ Fluorescent Antibody ☐ Method Unknown

1a. Result: ☐ RSV A ☐ RSV B ☐ RSV A & B ☐ RSV, unspecified ☐ Negative

1b. Specimen collection date: _____ / _____ / _____

1c. Testing facility: _____

1d. Specimen Type: ☐ Upper (Nose/Throat/NP/OP) ☐ Lower (BAL/tracheal aspirate) ☐ Unknown ☐ Other, specify: _____

2. Test 2: ☐ Antigen ☐ Molecular Assay ☐ Viral Culture ☐ Serology ☐ Fluorescent Antibody ☐ Method Unknown

2a. Result: ☐ RSV A ☐ RSV B ☐ RSV A & B ☐ RSV, unspecified ☐ Negative

2b. Specimen collection date: _____ / _____ / _____

1c. Testing facility: _____

1d. Specimen Type: ☐ Upper (Nose/Throat/NP/OP) ☐ Lower (BAL/tracheal aspirate) ☐ Unknown ☐ Other, specify: _____

E. Intensive Care Unit Interventions

1. Was the patient admitted to an intensive care unit (PICU/ICU)? ☐ Yes ☐ No ☐ Unknown

1a. Date of 1st ICU Admission: _____ / _____ / _____ ☐ Unknown **1b. Date of 1st ICU Discharge:** _____ / _____ / _____ ☐ Unknown

1c. Date of 2nd ICU Admission: _____ / _____ / _____ ☐ Unknown **1d. Date of 2nd ICU Discharge:** _____ / _____ / _____ ☐ Unknown

2. Non-invasive mechanical ventilation? (e.g., BiPAP, CPAP) ☐ Yes ☐ No ☐ Unknown

3. Invasive mechanical ventilation? (e.g., intubated) ☐ Yes ☐ No ☐ Unknown

4. ECMO? ☐ Yes ☐ No ☐ Unknown

5. Vasopressors in ICU? ☐ Yes ☐ No ☐ Unknown

(Common vasopressors are Dobutamine, Dopamine, Epinephrine, Milrinone, Neosynephrine, Norepinephrine, Vasopressin)

REDCap Record ID: ____ ____ ____ | NNDSS Record ID: _____ | Mortality Case ID: ____ ____ ____ ____ ____

F. Admission and Patient History

1. Acute signs/symptoms (began or worsened within 2 weeks prior to admission, if applicable, or positive RSV test): ☐ None of those listed below ☐ Unknown

Non-respiratory symptoms ☐ Altered mental status/confusion ☐ Fever/chills ☐ Seizures

Respiratory symptoms ☐ Congested/runny nose ☐ Cough ☐ Shortness of breath/respiratory distress ☐ Sore throat ☐ URI/ILI ☐ Wheezing

For cases < 2 years ☐ Apnea ☐ Hypothermia ☐ Inability to eat/poor feeding ☐ Lethargy ☐ Cyanosis ☐ Decreased vocalization/stridor ☐ Dehydration

2. Date of onset of acute respiratory symptoms (within 2 weeks before a positive RSV test): ____ / ____ / ____ ☐ Unknown ☐ Not applicable

3. Maximum respiratory rate (breaths/min) within 24 hours of admission (if applicable) or death _____ ☐ Unknown

4. Lowest systolic blood pressure within 24 hours of admission (if applicable) or death _____ ☐ Unknown

5. Minimum oxygen saturation on room air [RA] only within 24 hours admission (if applicable) or death _____ ☐ Unknown

6. BMI _____ ☐ Unknown | **7. Height** _____ ☐ Inch ☐ Cm ☐ Unknown | **8. Weight** _____ ☐ Lbs ☐ Kg ☐ Unknown

9. Where did patient reside at the time of hospitalization (if applicable) or death:

☐ Private residence ☐ Hospice ☐ Homeless/shelter ☐ Unknown
☐ Home with services ☐ Facility ☐ Corrections facility ☐ Other, specify: _____

G. Underlying Medical Conditions

1. Did patient have any of the following pre-existing medical conditions? (Check all that apply) ☐ Yes ☐ No ☐ Unknown

1a. Asthma/Reactive Airway Disease ☐ Yes ☐ No/Unknown

1b. Chronic Lung Disease ☐ Yes ☐ No/Unknown
- ☐ Active tuberculosis/TB
- ☐ Cystic fibrosis
- ☐ Emphysema/COPD
- ☐ Chronic bronchitis
- ☐ Chronic respiratory failure
- ☐ Other, specify: _____

1c. Chronic Metabolic Disease ☐ Yes ☐ No/Unknown
- ☐ Diabetes mellitus
- ☐ Thyroid dysfunction
- ☐ Other, specify: _____

1d. Blood disorders/Hemoglobinopathy ☐ Yes ☐ No/Unknown
- ☐ Aplastic anemia
- ☐ Sickle cell disease
- ☐ Splenectomy/Asplenia
- ☐ Other, specify: _____

1e. Cardiovascular Disease ☐ Yes ☐ No/Unknown
- ☐ Aortic aneurysm
- ☐ Aortic stenosis
- ☐ Atrial fibrillation
- ☐ Cardiomyopathy
- ☐ Atherosclerotic cardiovascular disease (ASCVD)
- ☐ Cerebral vascular incident/Stroke
- ☐ Congenital heart disease
- ☐ Coronary artery disease (CAD)
- ☐ Heart failure/CHF
- ☐ Other, specify: _____

1f. Neuromuscular disorder ☐ Yes ☐ No/Unknown
- ☐ Duchenne muscular dystrophy
- ☐ Muscular dystrophy
- ☐ Multiple sclerosis
- ☐ Mitochondrial disorder
- ☐ Myasthenia gravis
- ☐ Parkinson's disease
- ☐ Other, specify: _____

1g. Neurologic disorder ☐ Yes ☐ No/Unknown
- ☐ Cerebral palsy
- ☐ Cognitive dysfunction
- ☐ Dementia/Alzheimer's disease
- ☐ Developmental delay
- ☐ Down syndrome
- ☐ Plegias/Paralysis
- ☐ Seizure/Seizure disorder
- ☐ Other, specify: _____

1h. History of Guillain-Barré Syndrome ☐ Yes ☐ No/Unknown

1i. Immunocompromised Condition ☐ Yes ☐ No/Unknown
- ☐ AIDS or CD4 count < 200
- ☐ Cancer: current/in treatment or diagnosed in last 12 months
- ☐ Complement deficiency
- ☐ HIV Infection
- ☐ Immunoglobulin deficiency
- ☐ Immunosuppressive therapy
- ☐ Organ transplant
- ☐ Stem cell transplant (e.g., bone marrow transplant)
- ☐ Steroid therapy (taken within 2 weeks of admission)
- ☐ Other, specify: _____

1j. Renal Disease ☐ Yes ☐ No/Unknown
- ☐ Chronic kidney disease/chronic renal insufficiency
- ☐ End stage renal disease/Dialysis
- ☐ Glomerulonephritis
- ☐ Nephrotic syndrome
- ☐ Other, specify: _____

1k. Liver disease ☐ Yes ☐ No/Unknown
- ☐ Cirrhosis
- ☐ Viral hepatitis (B or C)
- ☐ Other, specify: _____

1l. Any obesity ☐ Yes ☐ No/Unknown
- ☐ Obese
- ☐ Morbidly obese (ADULTS ONLY)

1m. Pregnant ☐ Yes ☐ No/Unknown

If pregnant,
Total # of pregnancies to date: ____ ☐ Unknown
Total # of pregnancies to date that resulted in a live birth: ____ ☐ Unknown
Specify total # of fetuses for current pregnancy: ☐ 1 ☐ 2 ☐ 3 ☐ >3 ☐ Unknown
Specify, gestational age in weeks: ____ ☐ Unknown
If gestational age in weeks unknown, specify trimester of pregnancy:
☐ 1st (0 to 13 6/7 weeks) ☐ 3rd (28 0/7 to end) ☐ 2nd (14 0/7 to 27 6/7 weeks) ☐ Unknown

1n. Post-partum (two weeks or less) ☐ Yes ☐ No/Unknown

1o. Other ☐ Yes ☐ No/Unknown
- ☐ Systemic lupus erythematosus/SLE/Lupus
- ☐ Other, specify: _____

1p. PEDIATRIC CASES ONLY
- ☐ Abnormality of airway ☐ Chronic lung disease of prematurity/BPD
- ☐ Congenital heart disease
  Specify:
  - ☐ Atrial septal defect ☐ Ventricular septal defect
  - ☐ Patent ductus arteriosus ☐ Tetralogy of Fallot
  - ☐ Pulmonary stenosis ☐ Other, specify: _____
- ☐ Congenital immunodeficiency
- ☐ Genetic/metabolic disorder (Other than Down)
- ☐ History of febrile seizures

1q. For cases <2 years:
- ☐ Prematurity (gestational age at birth in weeks: _____)
- ☐ Unknown gestational age at birth

REDCap Record ID: ____ ____ ____ | NNDSS Record ID: _____ | Mortality Case ID: ____ ____ ____ ____ ____

H. Bacterial Pathogens – *Sterile or respiratory site only*

1. Were any bacterial culture tests performed with a collection date within 3 days of admission (if applicable) or within 3 days prior to death or 24 hours after death? ☐ Yes ☐ No ☐ Unknown

2. If yes, was there a positive culture for a bacterial pathogen? ☐ Yes ☐ No ☐ Unknown

2a. If yes, specify Pathogen 1: _____

2b. Date of culture: ____ / ____ / ____

2c. Site where pathogen identified: ☐ Blood ☐ Bronchoalveolar lavage (BAL) ☐ Pleural fluid ☐ Cerebrospinal fluid (CSF) ☐ Sputum ☐ Endotracheal aspirate ☐ Other, specify: _____

2d. If staphylococcus aureus, specify: ☐ methicillin resistant (MRSA) ☐ methicillin sensitive (MSSA) ☐ sensitivity unknown

3a. If yes, specify Pathogen 2: _____

3b. Date of culture: ____ / ____ / ____

3c. Site where pathogen identified: ☐ Blood ☐ Bronchoalveolar lavage (BAL) ☐ Pleural fluid ☐ Cerebrospinal fluid (CSF) ☐ Sputum ☐ Endotracheal aspirate ☐ Other, specify: _____

3d. If staphylococcus aureus, specify: ☐ methicillin resistant (MRSA) ☐ methicillin sensitive (MSSA) ☐ sensitivity unknown

I. Viral Pathogens

1. Was patient tested for any of the following viral respiratory pathogens with a collection date within 14 days prior to death or 24 hours after death? ☐ Yes ☐ No ☐ Unknown

				Specimen Collection Date:	Specimen Type:
1a. Flu A (If positive, specify type/subtype, if known): _____	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other
1b. Flu B (If positive, specify lineage, if known): _____	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other
1c. Flu (no subtype specified)	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other
1d. Adenovirus	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other
1e. Parainfluenza 1	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other
1f. Parainfluenza 2	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other
1g. Parainfluenza 3	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other
1h. Parainfluenza 4	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other
1i. Human metapneumovirus	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other
1j. Rhinovirus/Enterovirus	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other
1k. Coronavirus HKU1	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other
1l. Coronavirus OC43	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other
1m. Coronavirus NL63	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other
1n. Coronavirus 299E	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other
1o. SARS CoV 2	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other
1p. Other: _____	☐ Yes, positive	☐ Yes, negative	☐ Not tested/Unknown	____ / ____ / ____	☐ Upper ☐ Lower ☐ Unk/Other

J. RSV Treatment

1. Did the patient receive ribavirin or an RSV antiviral treatment during the course of this illness? ☐ Yes ☐ No ☐ Unknown

1b. Treatment: ☐ ribavirin ☐ other, specify: _____ ☐ Unknown

1c. Start date: ____ / ____ / ____ ☐ Unknown **End date:** ____ / ____ / ____ ☐ Unknown

For pediatric cases ≤2 years:

1. Did the patient receive palivizumab (Synagis) for the current RSV season? ☐ Yes ☐ No ☐ Unknown

REDCap Record ID: ____ ____ ____	NNDSS Record ID: _____	Mortality Case ID: ____ ____ ____ ____ ____

K. Discharge Summary

1. Did the patient have any of the following new diagnoses at discharge? (check all that apply) ☐ No discharge summary available ☐ Not Applicable

Acute encephalopathy/ encephalitis	☐ Yes ☐ No/Unk	Bronchiolitis	☐ Yes ☐ No/Unk	Invasive pulmonary aspergillosis	☐ Yes ☐ No/Unk
Acute Myocardial Infarction	☐ Yes ☐ No/Unk	Bronchitis	☐ Yes ☐ No/Unk	Reyes syndrome	☐ Yes ☐ No/Unk
Acute Myocarditis	☐ Yes ☐ No/Unk	Chronic lung disease of prematurity/BPD	☐ Yes ☐ No/Unk	Rhabdomyolysis	☐ Yes ☐ No/Unk
Acute Renal Failure/ Acute Kidney Injury	☐ Yes ☐ No/Unk	Congestive Heart Failure	☐ Yes ☐ No/Unk	Pneumonia	☐ Yes ☐ No/Unk
Acute respiratory distress syndrome (ARDS)	☐ Yes ☐ No/Unk	COPD exacerbation	☐ Yes ☐ No/Unk	Sepsis	☐ Yes ☐ No/Unk
Acute respiratory failure	☐ Yes ☐ No/Unk	Diabetic Ketoacidosis	☐ Yes ☐ No/Unk	Seizures	☐ Yes ☐ No/Unk
Asthma exacerbation	☐ Yes ☐ No/Unk	Guillan-Barre syndrome	☐ Yes ☐ No/Unk	Stroke (CVA)	☐ Yes ☐ No/Unk
Bacteremia	☐ Yes ☐ No/Unk	Hemophagocytic syndrome	☐ Yes ☐ No/Unk		

For patients who were pregnant on admission (if applicable) or at time of RSV test:

2. Indicate pregnancy status at discharge or death: ☐ Still pregnant ☐ No longer pregnant ☐ Unknown

2a. If patient was no longer pregnant at discharge (if applicable) or at time of death, indicate pregnancy outcome:

☐ Healthy newborn ☐ Preterm delivery, gestational age in weeks: _____ ☐ Ill newborn
☐ Miscarriage (intrauterine death at <22 weeks GA) ☐ Stillbirth (intrauterine death at ≥ 22 weeks GA)
☐ Newborn died ☐ Abortion ☐ Unknown

2b. If no longer pregnant, indicate date of delivery or end of pregnancy: _____ / _____ / _____ ☐ Unknown

L. ICD 10 Discharge Diagnoses (to be recorded in order of appearance)

ICD 10 codes available? ☐ Yes ☐ No ☐ Not Applicable

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

M. Additional Comments

U.S. DEPARTMENT OF
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AND PREVENTION
ATLANTA, GA 30333

RSV-Associated Mortality Case Report Form

Part 2 - Death Certificate Abstraction

Is information from the death certificate available? ☐ Yes ☐ No ☐ Unknown (If "No" or "Unknown", stop here.)

REDCap Record ID: ____ ____ ____ | **NNDSS Record ID:** _____ | **Mortality Case ID:** ____ ____ ____ ____ ____

A. Patient Information – shaded fields not sent to CDC
(Data from vital records or death certificate.)

1. First name:	**2. Last name:**	**3. SSN:**
4. Zip code:	**5. County of residence:**	**6. Date of birth** (mm/dd/yyyy)**:** ____/____/____
7. Sex: ☐ Male ☐ Female	**8. Date of positive RSV test** (mm/dd/yyyy)**:** ____/____/____	**9. Date of death** (mm/dd/yyyy)**:** ____/____/____

10. Was the decedent treated at an emergency room or hospital within 60 days of death?
☐ Yes ☐ No ☐ Unknown

10a. If yes, visit or admission date (mm/dd/yyyy)**:** ____/____/____ (if unknown, enter 01/01/9999)

10b. If hospitalized, discharge date (mm/dd/yyyy)**:** ____/____/____ (if unknown, enter 01/01/9999)

11. Clinical record matching comments (including inconsistencies, misspellings, other information needed for match):

B. Death Certificate: Place of Death

1. If death occurred in a hospital: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on arrival

2. If death occurred somewhere other than hospital: ☐ Hospice facility ☐ Nursing home/LTCF ☐ Decedent's home ☐ Unknown
☐ Other, specify: _____

3. City/Town: ☐ Unknown	**4. State:** ☐ Unknown

C. Death Certificate: Date and Time of Death

1. Date pronounced dead: ____/____/____ ☐ Unknown	**2. Actual/presumed date of death:** ____/____/____ ☐ Unknown

D. Death Certificate: Immediate and Underlying Causes of Death

1a. Immediate Cause ICD Code:	**1b. Free Text:**

1c. Approximate interval (Onset to death): _____
☐ secs ☐ mins ☐ hours ☐ days ☐ weeks ☐ months ☐ years ☐ other, specify _____ ☐ Unknown interval

2a. Underlying Cause ICD Code:	**2b. Free Text:**

2c. Approximate interval (Onset to death): _____
☐ secs ☐ mins ☐ hours ☐ days ☐ weeks ☐ months ☐ years ☐ other, specify _____ ☐ Unknown interval

3a. Underlying Cause ICD Code:	**3b. Free Text:**

3c. Approximate interval (Onset to death): _____
☐ secs ☐ mins ☐ hours ☐ days ☐ weeks ☐ months ☐ years ☐ other, specify _____ ☐ Unknown interval

4a. Underlying Cause ICD Code:	**4b. Free Text:**

4c. Approximate interval (Onset to death): _____
☐ secs ☐ mins ☐ hours ☐ days ☐ weeks ☐ months ☐ years ☐ other, specify _____ ☐ Unknown interval

5. Significant conditions contributing to death:

REDCap Record ID: ____ ____ ____	NNDSS Record ID: _____	Mortality Case ID: ____ ____ ____ ____ ____

E. Death Certificate: Additional Information from the Death Certificate				
1. Was an autopsy performed? ☐ Yes ☐ No ☐ Unknown				
2. Certifier:	☐ Certifying physician	☐ Medical Examiner/Coroner	☐ Other, specify: _____	☐ Unknown
3. Decedent's Ethnicity:	☐ Hispanic or Latino	☐ Non-Hispanic or Latino	☐ Not specified	
4. Decedent's Race:	☐ White	☐ Black or African American	☐ Asian/Pacific Island	☐ American Indian /Alaska Native
	☐ Multiracial	☐ Not specified	☐ Other, specify: _____	

F. Additional Comments (This field is sent to CDC – *do not include identifiable information)*