

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: _____ Days 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treated with supplemental oxygen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treated with bronchodilators?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treated with antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalized? If Yes, admission date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, was the patient admitted to the Intensive Care Unit (ICU)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes was the patient placed on non-invasive ventilation (BiPAP/CPAP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, was the patient intubated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, was the patient placed on ECMO?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the patient die? If Yes, date of death: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

General Pathogen Laboratory Testing (mark all that apply)									
Pathogen	Pos	Neg	Pending	Not Done	Pathogen	Pos	Neg	Pending	Not Done
Influenza A PCR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rhinovirus and/or Enterovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza B PCR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coronavirus (not MERS-CoV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza Rapid Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Chlamydomphila pneumoniae</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Mycoplasma pneumoniae</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Human metapneumovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Legionella pneumophila</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parainfluenzavirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Streptococcus pneumoniae</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adenovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood culture <input type="checkbox"/> Yes <input type="checkbox"/> No If positive, which bacteria: _____				
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CSF culture <input type="checkbox"/> Yes <input type="checkbox"/> No If positive, which bacteria: _____				
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sputum culture <input type="checkbox"/> Yes <input type="checkbox"/> No If positive, which bacteria: _____				

Enterovirus Typing - Specimen Type	Date Collected	Specimen ID	Enterovirus Typing - Specimen Type	Date Collected	Specimen ID
<input type="checkbox"/> NP <input type="checkbox"/> OP <input type="checkbox"/> NP/OP (check one)	_____	_____	Bronchoalveolar 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: _____