

## 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

	<u>Yes</u>	<u>No</u>	<u>Unknown</u>
<b>Is/Was the patient:</b> 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?			
<b>Did the patient die?</b> 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					<i>Chlamydomphila pneumoniae</i>				
RSV					<i>Mycoplasma pneumoniae</i>				
Human metapneumovirus					<i>Legionella pneumophila</i>				
Parainfluenzavirus					<i>Streptococcus pneumoniae</i>				
Adenovirus					Blood culture <input type="checkbox"/> Yes <input type="checkbox"/> No If positive, which bacteria _____				
Other: _____					CSF culture <input type="checkbox"/> Yes <input type="checkbox"/> No If positive, which bacteria _____				
Other: _____					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
NP OP NP/OP (circle 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: \_\_\_\_\_