

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					<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: _____