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?	☐	☐	☐
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	☐	☐	☐	☐	*Chlamydophila pneumoniae*	☐	☐	☐	☐
RSV	☐	☐	☐	☐	*Mycoplasma pneumoniae*	☐	☐	☐	☐
Human metapneumovirus	☐	☐	☐	☐	*Legionella pneumophila*	☐	☐	☐	☐
Parainfluenzavirus	☐	☐	☐	☐	*Streptococcus pneumoniae*	☐	☐	☐	☐
Adenovirus	☐	☐	☐	☐	Blood culture ☐ Yes ☐ No If positive, which bacteria: _____				
Other: _____	☐	☐	☐	☐	CSF culture ☐ Yes ☐ No If positive, which bacteria: _____				
Other: _____	☐	☐	☐	☐	Sputum culture ☐ Yes ☐ 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 (check one)	_____	_____	Bronchoalvelolar 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:*** _____