Pediatric COVID-19-Associated Mortality Case Report Form

This case report form should be completed for any patient who meets criteria for a respiratory syncytial virus-associated pediatric death defined as:

- Death in an individual <18 years of age resulting from an illness clinically compatible with COVID-19, AND
- There was no period of complete recovery between the COVID-19 illness and death, AND
- There is no alternative agreed-upon cause of death, AND
- Case meets confirmed or presumptive laboratory evidence for COVID-19*.

Completed case report forms should be sent via secure email to CDS.RESP@doh.nj.gov within 24 hours of discharge or death.

*** COVID-19 Confirmatory Laboratory Evidence**:
Detection of SARS-CoV-2 nucleic acid in a clinical or post-mortem specimen using a diagnostic molecular test (e.g., NAAT) performed by a CLIA-certified provider, OR
Detection of SARS-CoV-2 RNA in a clinical or post-mortem specimen by genomic sequencing, OR
Detection of SARS-CoV-2 specific antigen by diagnostic immunocytochemistry staining performed by a CLIA-certified provider.
COVID-19 Presumptive Laboratory Evidence:
Detection of SARS-CoV-2 specific antigen in a clinical or post-mortem specimen using a diagnostic test performed by a CLIA-certified provider.

Pediatric COVID-19 Associated Mortality Case Report Form

STATE USE ONLY – DO NOT SEND INFORMATION *IN THIS SECTION* TO CDC

Last Name: _____ First Name: _____ County: _____

Address: _____ City: _____ State, Zip: _____

Site Use: Medical Record or Other Identifier:

Reporter Information

1. Reporter Name	2. Case Classification: ☐ Confirmed ☐ Not Confirmed
3. Data Entry Completed: ☐ Yes ☐ No	3a. If yes, completed date: _____/_____/_____
4. Is this an eligible RESP-NET case? ☐ Yes ☐ No ☐ Unknown	4a. If yes, RESP-NET Case ID: _____

Demographic Information

5. State:	6. County:	7. State ID:	8. REDCap ID:

9. Date of birth: _____/ _____/ _____ MM DD YYYY	10. Age: _____ O Days (if <1 month) O Months (if < 1 year) O Years (if ≥ 1 year)	11a. Is sex known? O Yes O No 11b. Sex: O Male O Female

12a. Is race and/or ethnicity known? O Yes O No

12b. Race and/or ethnicity (Select all that apply)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander
☐ White

Death Information

13. Date of illness onset: _____/ _____/ _____ O Unknown
MM DD YYYY

13a. Comments regarding onset date: _____

14. Date of death: _____/ _____/_____
MM DD YYYY

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

16. Location of death? O At home or in transit to hospital O Emergency Department (ED) O Inpatient Ward O ICU
O Hospice Facility
O Other: _____

Medical Care

17. Was this child seen at an outpatient healthcare facility (e.g., ED, clinic, other) within 14 days prior to death?

O Yes O No O Unknown

17a. If yes, what was the most recent date of outpatient visit? _____/ _____/ _____
MM DD YYYY

18. Did cardiac/respiratory arrest occur outside the hospital? O Yes O No O Unknown

19. Was there a hospital admission associated with this acute illness? O Yes O No O Unknown

19a. If yes, what was the most recent date of admission? _____/_____/_____
MM DD YYYY

19b. Was the child admitted to an intensive care unit (PICU/ICU)? O Yes O No O Unknown

19c. Was the child placed on mechanical ventilation? O Yes O No O Unknown

SARS-CoV-2 Testing Results *(can add up to four clinical test results in database; start with most recent positive test associated with this acute illness)*

	Test Type	Test Result	Specimen Collection Date
20. Clinical Test 1	O Rapid Antigen Test O Molecular Assay (e.g., RT-PCR, RVP) O Method unknown/ Provider note only O Other, specify: _____	O Positive O Negative	____/ ____/ ____
21. Clinical Test 2	O Rapid Antigen Test O Molecular Assay (e.g., RT-PCR, RVP) O Method unknown/ Provider note only O Other, specify: _____	O Positive O Negative	____/ ____/ ____
22. Clinical Test 3	O Rapid Antigen Test O Molecular Assay (e.g., RT-PCR, RVP) O Method unknown/ Provider note only O Other, specify: _____	O Positive O Negative	_____/ _____/ _____
23. Clinical Test 4	O Rapid Antigen Test O Molecular Assay (e.g., RT-PCR, RVP) O Method unknown/ Provider note only O Other, specify: _____	O Positive O Negative	_____/ _____/ _____

24. Was there a positive result on a COVID-19 home test (e.g., a rapid antigen) associated with this acute illness? O Yes O No O Unknown

24a. If yes, Date of test: O Unknown OR _____/ _____/_____ (if more than one, please record the date for the **first** known positive result).

25. Additional comments about test results (do not include identifiable information):

Additional Pathogen Testing (Potential Coinfections)

26. Was there a positive result for other viral respiratory pathogens associated with this acute illness? O Yes O No O Unknown

If "No" or "Unknown", skip to Question 27.

Please add other respiratory viruses detected from a respiratory specimen (e.g., NP, OP, throat, or nasal).

Pathogen	**Specimen Collection Date**
☐ Influenza A (subtype, if known: _____)	Date _____/ _____/ _____
☐ Influenza B (lineage, if known: _____)	Date _____/ _____/ _____
☐ Influenza (not specified)	Date _____/ _____/ _____
☐ Adenovirus	Date _____/ _____/ _____
☐ Common Human Coronavirus (229E, HKU1, NL63, OC43) (type, if known: _____)	Date _____/ _____/ _____
☐ Human Metapneumovirus	Date _____/ _____/ _____
☐ Parainfluenza (1,2,3,4) (type, if known: _____)	Date _____/ _____/ _____
☐ Rhino/Enterovirus	Date _____/ _____/ _____
☐ RSV	Date _____/ _____/ _____
☐ Other (_____)	Date _____/ _____/ _____

27. Please describe any other pathogens (bacterial/ fungal/ viral/ other) detected from a sterile (e.g., blood, cerebrospinal fluid (CSF), pleural fluid) or respiratory site (e.g., sputum, bronchoalveolar lavage (BAL), endotracheal aspirate, NP, OP, throat, or nasal). Specimens collected greater than 24 hours after death may represent contamination. Include date of collection & specimen type/site:

Pathogen Detected:	**Collection Date:**	**Specimen type/site:**	**Comments:**
_____	_____/ _____/ _____	_____	_____
_____	_____/ _____/ _____	_____	_____

Clinical Diagnoses and Complications

28. Did complications occur during the acute illness O Yes O No O Unknown

28a. **If yes,** check all complications that occurred during the acute illness:

☐ **Cardiovascular**
- ☐ Acute Myocardial Infarction
- ☐ Acute Myocarditis
- ☐ Shock
- ☐ Vasculitis

☐ **Renal**
- ☐ Acute Renal Failure/ Acute Kidney Injury

☐ **Neurologic**
- ☐ Encephalopathy/ Encephalitis
- ☐ Seizures
- ☐ Stroke (CVA)

☐ **Respiratory**
- ☐ Acute Respiratory Distress Syndrome (ARDS)
- ☐ Acute Respiratory Failure
- ☐ Asthma exacerbation
- ☐ Bronchiolitis
- ☐ Bronchitis
- ☐ Croup
- ☐ Hemorrhagic Pneumonia/ pneumonitis
- ☐ Pneumonia

☐ **Endocrine**
- ☐ Diabetic Ketoacidosis (DKA)

☐ **Immunologic:**
- ☐ Autoimmune (Not MIS-C)
- ☐ Multisystem Inflammatory Syndrome in Children (MIS-C; for COVID-19 only)

☐ **Other**
- ☐ Pulmonary embolism (PE)/ Other thrombosis/ Embolism/ Coagulopathy
- ☐ Sepsis
- ☐ Other (specify): _____ _____

Pre-existing Conditions

29. Did the child have any medical conditions that existed before the start of the acute illness? O Yes O No O Unknown

29a. If yes, check all medical conditions that existed before the start of the acute illness:

☐ **Cardiovascular Disease**
- ☐ Congenital heart disease
- ☐ Other (specify) _____

☐ **Endocrine Disorder**
- ☐ Diabetes mellitus
- ☐ Other (specify) _____

☐ **Gastrointestinal/Liver Disease**

Specify: _____

☐ **Genetic and Developmental Conditions**
- ☐ Moderate to severe developmental delay
- ☐ Chromosomal abnormality/ genetic syndrome
- ☐ Mitochondrial Disorder (specify): _____
- ☐ Other (specify) _____

☐ **Immunocompromised Conditions**
- ☐ Autoimmune conditions (specify)_____
- ☐ Cancer (diagnosis and/or treatment began in previous 12 months) (specify): _____
- ☐ Other (specify) _____

☐ **Neurologic Disorder**
- ☐ Cerebral Palsy
- ☐ Neuromuscular disorder (e.g. muscular dystrophy) (specify): _____
- ☐ Seizure disorder
- ☐ History of febrile seizures
- ☐ Other (specify) _____

☐ **Renal Disease**

Specify: _____

☐ **Respiratory Disease**
- ☐ Asthma/ reactive airway disease
- ☐ Cystic fibrosis
- ☐ Chronic lung disease of prematurity/BPD
- ☐ Other (specify) _____

☐ **Other**
- ☐ Hemoglobinopathy (e.g. sickle cell disease)
- ☐ Obesity
- ☐ Premature at birth (for cases <2 years of age) (specify gestational age): _____ weeks
- ☐ Pregnant (specify gestational age): _____ weeks
- ☐ Skin or soft tissue infection (SSTI)
- ☐ Other (specify) _____

Medication and Therapy History

30. Did this child receive Paxlovid treatment for this acute illness? O Yes O No O Unknown

COVID-19 Vaccine History

31. Does the child have documentation of a COVID-19 vaccine in the 12 months prior to death O Yes O No O Unknown
If no or unknown, skip question 30 a-d.

31a. **COVID-19 vaccine doses received** (*For cases ≥6 months old, record up to 4 doses of COVID-19 vaccine received in the 12 months prior to death, beginning with the most recent)*

Dose Date	**Dose Product**
_____/ _____/ _____ Month Day Year ☐ Unk. ☐ Unk. ☐ Unk.	☐ Pfizer-BioNTech COVID-19 Vaccine ☐ Moderna COVID-19 Vaccine ☐ Novavax COVID-19 Vaccine ☐ Unknown ☐ Other, specify _____

31b. **COVID-19 vaccine doses received** (*For cases ≥6 months old, record up to 4 doses of COVID-19 vaccine received in the 12 months prior to death, beginning with the most recent)*

Dose Date	**Dose Product**
_____/ _____/ _____ Month Day Year ☐ Unk. ☐ Unk. ☐ Unk.	☐ Pfizer-BioNTech COVID-19 Vaccine ☐ Moderna COVID-19 Vaccine ☐ Novavax COVID-19 Vaccine ☐ Unknown ☐ Other, specify _____

31c. **COVID-19 vaccine doses received** (*For cases ≥6 months old, record up to 4 doses of COVID-19 vaccine received in the 12 months prior to death, beginning with the most recent)*

Dose Date	**Dose Product**
_____/ _____/ _____ Month Day Year ☐ Unk. ☐ Unk. ☐ Unk.	☐ Pfizer-BioNTech COVID-19 Vaccine ☐ Moderna COVID-19 Vaccine ☐ Novavax COVID-19 Vaccine ☐ Unknown ☐ Other, specify _____

31d. **COVID-19 vaccine doses received** (*For cases ≥6 months old, record up to 4 doses of COVID-19 vaccine received in the 12 months prior to death, beginning with the most recent)*

Dose Date	**Dose Product**
_____/ _____/ _____ Month Day Year ☐ Unk. ☐ Unk. ☐ Unk.	☐ Pfizer-BioNTech COVID-19 Vaccine ☐ Moderna COVID-19 Vaccine ☐ Novavax COVID-19 Vaccine ☐ Unknown ☐ Other, specify _____

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

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This section is optional. If you choose to complete this section, there is a separate form in REDCap to enter the data.

Addendum - Death Certificate Abstraction (Enhanced Data Collection)

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

Patient Information – these fields are for linking/case ascertainment only and are not sent to CDC *(Use data from vital records or death certificate and clinical/autopsy/ME/other available data sources.)*		
1. First name:	**2. Last name:**	**3. Local Identifier:**
4. Zip code:	**5. County of residence:**	**6. Date of birth** (mm/dd/yyyy)**:** _____ / _____ / _____
7. Sex: ☐ Male ☐ Female	**8. Date of positive COVID-19 test** (mm/dd/yyyy)**:** _____ / _____ / _____	**9. Date of death** (mm/dd/yyyy)**:** _____ / _____ / _____
10. Clinical record matching comments (including inconsistencies, misspellings, other information needed for match):		

Death Certificate: Date and Time of Death
1. Actual/presumed date of death: ____ / ____ / ____ ☐ Unknown

Death Certificate: Immediate and Underlying Causes of Death	
2a. Immediate Cause ICD Code:	**3a. Free Text:**
2b. Underlying Cause ICD Code:	**3b. Free Text:**
2c. Underlying Cause ICD Code:	**3c. Free Text:**
2d. Underlying Cause ICD Code:	**3d. Free Text:**

4. Other significant conditions contributing to death:

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

Additional Comments from Death Certificate (This field is sent to CDC – *do not include identifiable information)*

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