



## Pediatric RSV-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 RSV, AND
- There was no period of complete recovery between the RSV illness and death, AND
- There is no alternative agreed-upon cause of death, AND
- Case meets confirmed laboratory evidence for RSV\*.

Completed case report forms should be sent via secure email to the local health department where the patient resides and the NJDOH Communicable Disease Service Respiratory team [CDS.RESP@doh.nj.gov](mailto:CDS.RESP@doh.nj.gov) by the next business day.

**\* RSV Confirmatory Laboratory Evidence:**

Isolation of respiratory syncytial virus (RSV) by tissue cell culture

Detection of respiratory syncytial virus (RSV) nucleic acid by reverse-transcriptase polymerase chain reaction (RT-PCR) or other nucleic acid detection assay

Detection of respiratory syncytial virus (RSV) antigen by immunofluorescent antibody staining (direct or indirect)

Detection of respiratory syncytial virus (RSV) antigens by immunochromatographic or similar rapid laboratory test

Detection of respiratory syncytial virus (RSV) antigens from autopsy specimens by immunohistochemical (IHC) staining

## Pediatric RSV 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: <input type="checkbox"/> Confirmed <input type="checkbox"/> Not Confirmed
3. Data Entry Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	3a. If yes, completed date: ____/____/____
4. Is this an eligible RESP-NET case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: ____ <input type="radio"/> Days (if < 1 month) <input type="radio"/> Months (if < 1 year) <input type="radio"/> Years (if ≥ 1 year)	11a. Is sex known? <input type="radio"/> Yes <input type="radio"/> No 11b. Sex: <input type="radio"/> Male <input type="radio"/> Female	
12a. Is race and/or ethnicity known? <input type="radio"/> Yes <input type="radio"/> No			
12b. Race and/or ethnicity (Select all that apply)			
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic or Latino			

#### Death Information

13. Date of illness onset: ____/____/____ <input type="radio"/> Unknown MM DD YYYY
13a. Comments regarding onset date: _____
14. Date of death: ____/____/____ MM DD YYYY
15. Was an autopsy performed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
16. Location of death? <input type="radio"/> At home or in transit to hospital <input type="radio"/> Emergency Department (ED) <input type="radio"/> Inpatient Ward <input type="radio"/> ICU <input type="radio"/> Hospice Facility <input type="radio"/> Other: _____

## Medical Care

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

Yes  No  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?  Yes  No  Unknown

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

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

## RSV 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	<input type="radio"/> Antigen <input type="radio"/> Molecular Assay (e.g., RT-PCR, RVP) <input type="radio"/> Viral Culture <input type="radio"/> Fluorescent Antibody <input type="radio"/> Method unknown/ Provider note only <input type="radio"/> Other, specify: _____	<input type="radio"/> RSV A <input type="radio"/> RSV B <input type="radio"/> RSV A & B <input type="radio"/> RSV, unspecified <input type="radio"/> Negative	____/____/____
21. Clinical Test 2	<input type="radio"/> Antigen <input type="radio"/> Molecular Assay (e.g., RT-PCR, RVP) <input type="radio"/> Viral Culture <input type="radio"/> Fluorescent Antibody <input type="radio"/> Method unknown/ Provider note only <input type="radio"/> Other, specify: _____	<input type="radio"/> RSV A <input type="radio"/> RSV B <input type="radio"/> RSV A & B <input type="radio"/> RSV, unspecified <input type="radio"/> Negative	____/____/____
22. Clinical Test 3	<input type="radio"/> Antigen <input type="radio"/> Molecular Assay (e.g., RT-PCR, RVP) <input type="radio"/> Viral Culture <input type="radio"/> Fluorescent Antibody <input type="radio"/> Method unknown/ Provider note only <input type="radio"/> Other, specify: _____	<input type="radio"/> RSV A <input type="radio"/> RSV B <input type="radio"/> RSV A & B <input type="radio"/> RSV, unspecified <input type="radio"/> Negative	____/____/____
23. Clinical Test 4	<input type="radio"/> Antigen <input type="radio"/> Molecular Assay (e.g., RT-PCR, RVP) <input type="radio"/> Viral Culture <input type="radio"/> Fluorescent Antibody <input type="radio"/> Method unknown/ Provider note only <input type="radio"/> Other, specify: _____	<input type="radio"/> RSV A <input type="radio"/> RSV B <input type="radio"/> RSV A & B <input type="radio"/> RSV, unspecified <input type="radio"/> Negative	____/____/____

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

## Additional Pathogen Testing (Potential Coinfections)

25. 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 26.

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

<u>Pathogen</u>	<u>Specimen Collection Date</u>
<input type="checkbox"/> Influenza A (subtype, if known: _____)	Date ____ / ____ / ____
<input type="checkbox"/> Influenza B (lineage, if known: _____)	Date ____ / ____ / ____
<input type="checkbox"/> Influenza (not specified)	Date ____ / ____ / ____
<input type="checkbox"/> Adenovirus	Date ____ / ____ / ____
<input type="checkbox"/> Common Human Coronavirus (229E, HKU1, NL63, OC43) (type, if known: _____)	Date ____ / ____ / ____
<input type="checkbox"/> Human Metapneumovirus	Date ____ / ____ / ____
<input type="checkbox"/> Parainfluenza (1,2,3,4) (type, if known: _____)	Date ____ / ____ / ____
<input type="checkbox"/> Rhino/Enterovirus	Date ____ / ____ / ____
<input type="checkbox"/> SARS-CoV-2 Coronavirus	Date ____ / ____ / ____
<input type="checkbox"/> Other (_____)	Date ____ / ____ / ____

26. 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

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

27a. If yes, check all complications that occurred during the acute illness:

<input type="checkbox"/> <b>Cardiovascular</b>	<input type="checkbox"/> <b>Respiratory</b>	<input type="checkbox"/> <b>Immunologic</b>
<input type="checkbox"/> Acute Myocardial Infarction	<input type="checkbox"/> Acute Respiratory Distress Syndrome (ARDS)	<input type="checkbox"/> Autoimmune (Not MIS-C)
<input type="checkbox"/> Acute Myocarditis	<input type="checkbox"/> Acute Respiratory Failure	<input type="checkbox"/> Multisystem Inflammatory Syndrome in Children (MIS-C; for COVID-19 only)
<input type="checkbox"/> Shock	<input type="checkbox"/> Asthma exacerbation	<input type="checkbox"/> <b>Other</b>
<input type="checkbox"/> Vasculitis	<input type="checkbox"/> Bronchiolitis	<input type="checkbox"/> Pulmonary embolism (PE)/ Other thrombosis/ Embolism/ Coagulopathy
<input type="checkbox"/> <b>Renal</b>	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Sepsis
<input type="checkbox"/> Acute Renal Failure/ Acute Kidney Injury	<input type="checkbox"/> Croup	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> <b>Neurologic</b>	<input type="checkbox"/> Hemorrhagic Pneumonia/ pneumonitis	_____
<input type="checkbox"/> Encephalopathy/ Encephalitis	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Seizures	<input type="checkbox"/> <b>Endocrine</b>	
<input type="checkbox"/> Stroke (CVA)	<input type="checkbox"/> Diabetic Ketoacidosis (DKA)	

## Pre-existing Conditions

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

28a. 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

29. Did the child receive ribavirin during the course of this acute illness?     Yes     No     Unknown

## RSV Immunization History

### 30. For Pediatric Cases <2 years of age:

If yes, date of dose:

30a. Did the child receive nirsevimab (Beyfortus) in the 6 months prior to death?

Yes  No  Unknown

\_\_\_\_/\_\_\_\_/\_\_\_\_

30b. Did the child receive clesrovimab (Enflonsia) in the 6 months prior to death?

Yes  No  Unknown

\_\_\_\_/\_\_\_\_/\_\_\_\_

### 31. For Pediatric Cases <6 months of age:

Did the child's mother receive an RSV vaccination while pregnant with this child?

Yes  No  Unknown

\_\_\_\_/\_\_\_\_/\_\_\_\_

## Pediatric RSV-Associated Mortality Case Report Form



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 <i>(Use data from vital records or death certificate and clinical/autopsy/ME/other available data sources.)</i>		
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: <input type="checkbox"/> Male <input type="checkbox"/> Female	8. Date of positive RSV 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: ____/____/____ <input type="checkbox"/> 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. _____	6. _____	
2. _____	7. _____	
3. _____	8. _____	
4. _____	9. _____	
5. _____	10. _____	
Additional Comments from Death Certificate (This field is sent to CDC – do not include identifiable information)		