



BioFire® FilmArray® Respiratory Panels

Thank you for sharing your case with BioFire! Please fill out to the best of your ability. At the end of the form, provide your electronic signature, and the submit button will populate an email for submission to marketingassistants@biofire.com.

Patient demographics

Geographical location (List state only) _____

Male Female Urban Community

Age _____

Relevant medical history

Co-morbidities (Please list)

Current illness (Chief complaints and observations)

Physical exam (Include abnormal findings, vital signs, if known)

Heart rate _____ Blood pressure _____

Temperature _____ spO2 _____

Respiratory rate _____ Abnormal findings _____

CURB-65 score _____ SOFA score _____

Other imaging Yes No _____

Legend:

Y=yes

N=no

UNK=unknown

P=positive

N=negative

Imaging (If applicable)

BioFire RP Panel results (Check all that were detected)

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> Adenovirus | <input type="checkbox"/> Human metapneumovirus | <input type="checkbox"/> Influenza A/H3 | <input type="checkbox"/> Parainfluenza virus 4 | <input type="checkbox"/> <i>Mycoplasma pneumoniae</i> |
| <input type="checkbox"/> Coronavirus 229E | <input type="checkbox"/> Human rhinovirus/enterovirus | <input type="checkbox"/> Influenza B | <input type="checkbox"/> Respiratory syncytial virus | |
| <input type="checkbox"/> Coronavirus HKU1 | <input type="checkbox"/> Influenza A | <input type="checkbox"/> Parainfluenza virus 1 | <input type="checkbox"/> <i>Bordetella parapertussis</i> | |
| <input type="checkbox"/> Coronavirus NL63 | <input type="checkbox"/> Influenza A/H1 | <input type="checkbox"/> Parainfluenza virus 2 | <input type="checkbox"/> <i>Bordetella pertussis</i> | |
| <input type="checkbox"/> Coronavirus OC43 | <input type="checkbox"/> Influenza A/H1-2009 | <input type="checkbox"/> Parainfluenza virus 3 | <input type="checkbox"/> <i>Chlamydia pneumoniae</i> | |

Other diagnostics ordered and results

Impression (Including 1–3 differential diagnoses)

- _____
- _____
- _____

Treatment

Empiric antimicrobial regimen: _____

Steroid therapy initiated Yes No

Was antimicrobial therapy initiated prior to availability of BioFire RP Panel results? Yes No

Initiation/alteration of initial therapy based on BioFire RP Panel result (if applicable): _____

Initiation/alteration of therapy based on other test (if applicable): _____

Infection control

- Was patient placed in isolation before BioFire RP Panel result? Yes No Duration _____
- Was patient placed in isolation after BioFire RP Panel result? Yes No Duration _____
- Was patient removed from isolation based on BioFire RP Panel result? Yes No Duration _____
- Other infection control protocols changed based on BioFire RP Panel? Yes No Explain: _____

Outcomes (Length of stay, patient discharge, etc.)

Please give a description of the patient's progression or clinical courses given.

Did the BioFire RP Panel result impact patient care? If so, please explain.

Facility description (Check all that apply that best describes your facility)

- Tertiary care hospital Teaching hospital University hospital
- Community hospital Urgent care center Emergency center
- Clinic Physician office Other _____
- Adults/pediatrics Adults only Pediatrics only

Facility size (Number of beds) _____

Location (List state only) _____

Legal authorization to provide non-PHI data (Data use: check all that are permitted)

Case report for BioFire internal training purposes only

Case report for BioFire customer-facing materials

Please list any other restrictions: _____

Can we use geographical region of facility: Yes No

If yes, please select from the following US regions:

Northeast Mid-Atlantic Southeast

Midwest Gulf States Southwest

Pacific Northwest Other (specify) _____

Would you be interested in presenting your case as a poster with a short presentation? Yes No

Where? _____

Would you be interested in publishing your case? Yes No

What journal? _____

By providing this information, I and my institution agree that the information contained in this Case Report Form may be used by BioFire Diagnostics, LLC (BioFire) for marketing purposes, subject to the following limitations (if any):

Please omit the following information from any marketing use by BioFire:

Physician specialty

Type of hospital/facility (Size, teaching hospital, etc.)

Year of case

Location (List state only)

I also represent and warrant that I have the authority to permit BioFire to use the information contained herein. I understand that all identifying patient information will be removed prior to submission of this form to BioFire.

Name: _____ Signature: _____