SARS-CoV† Investigation Form

STOP: Prior to Creating this Investigation, you MUST Notify & Consult with Central Office
(800) 338-8374 (24-hour coverage)

†*Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV)*

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐ years ☐ months Current Sex: ☐ Female ☐ Male ☐ Unknown

Is the patient deceased? ☐ No ☐ Unknown ☐ Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐ Open ☐ Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐ No ☐ Unknown ☐ Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐ days ☐ hours ☐ minutes ☐ months ☐ unknown ☐ weeks ☐ years

Did the patient die from this illness? ☐ No ☐ Unknown ☐ Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐ No ☐ Unknown ☐ Yes Is this patient a food handler? ☐ No ☐ Unknown ☐ Yes

Is this case part of an outbreak? ☐ No ☐ Unknown ☐ Yes If yes, outbreak name:_____

Case Status: ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐ Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments:_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐ Reviewed (Complete) ☐ Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐ Reviewed (Not a case) ☐ Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐ Yes ☐ No

SEVERE ACUTE RESPIRATORY SYNDROME

Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS) Version 2

Supplement B: SARS Surveillance

Appendix B2: SARS Domestic Case Reporting Form

Form Approved
OMB No. 0920-0008

Person Details

1. IDs	
CDC ID #: *CDC ID WILL BE AUTOMATICALLY GENERATED*	Date reported to CDC: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
State ID #: _____	Jurisdiction:
Date reported to state or local health department: __ __ / __ __ / __ __ __ __ (m m d d y y y y)	
2. Submitted By	
Last Name:	First Name:
State:	Affiliation:
Phone:	E-mail:
3. Patient Information	
City of Residence:	
County of Residence:	
State of Residence:	
Age at onset: _____ ☐ Years ☐ Months	Sex: ☐ Male ☐ Female
Ethnicity: ☐ Non Hispanic ☐ Hispanic	Race *(Mark one or more)* ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown
Nationality/Citizenship:	
Residency: ☐ US Residency ☐ Non-US Residency	
4. Optional Patient Information	
Last Name: _____	First Name: _____

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
SAFER · HEALTHIER · PEOPLE™

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Was patient ever placed on mechanical ventilation?	☐ Yes ☐ No ☐ Unknown
Did patient die as a result of his/her illness?	☐ Yes ☐ No ☐ Unknown
If yes: Date of Death: __ __ / __ __ / __ __ __ __ m m d d y y y y	
Was an autopsy performed?	☐ Yes ☐ No ☐ Unknown
Was pathology consistent with pneumonia or RDS?	☐ Yes ☐ No ☐ Unknown

Epidemiologic Risk Factors

7. Occupation	
Is the individual a healthcare worker?* ** A person who has close contact to patients, patient care areas (e.g., patient room) or patient care items (e.g. linens, patient specimens).*	☐ Yes ☐ No ☐ Unknown
If yes: Specify healthcare worker type:	☐ Physician ☐ Nurse/PA ☐ Lab ☐ Other Specify: _____
Does patient have DIRECT patient care responsibilities?	☐ Yes ☐ No ☐ Unknown
If not a healthcare worker, please list occupation: _____	

8. Contact and Travel	
In the 10 days prior to symptom onset, did the patient have the following?	
A. Close contact in the 10 days prior to symptom onset with a confirmed SARS-CoV case or a probable SARS-CoV case? * ** SEE APPENDIX B1 FOR CLASSIFICATION DEFINITIONS*	☐ Yes If yes, go to section 9, then return ☐ No ☐ Unknown
B. Close contact with a person considered an RUI-2 or RUI-3? * ** SEE APPENDIX B1 FOR CLASSIFICATION DEFINITIONS*	☐ Yes If yes, go to section 9, then return ☐ No ☐ Unknown

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Was patient ever placed on mechanical ventilation?	☐ Yes ☐ No ☐ Unknown
Did patient die as a result of his/her illness?	☐ Yes ☐ No ☐ Unknown
If yes: Date of Death: __ __ / __ __ / __ __ __ __ m m d d y y y y	
Was an autopsy performed?	☐ Yes ☐ No ☐ Unknown
Was pathology consistent with pneumonia or RDS?	☐ Yes ☐ No ☐ Unknown

Epidemiologic Risk Factors

7. Occupation	
Is the individual a healthcare worker?* ** A person who has close contact to patients, patient care areas (e.g., patient room) or patient care items (e.g. linens, patient specimens).*	☐ Yes ☐ No ☐ Unknown
If yes: Specify healthcare worker type:	☐ Physician ☐ Nurse/PA ☐ Lab ☐ Other Specify: _____
Does patient have DIRECT patient care responsibilities?	☐ Yes ☐ No ☐ Unknown
If not a healthcare worker, please list occupation: _____	

8. Contact and Travel	
In the 10 days prior to symptom onset, did the patient have the following?	
A. Close contact in the 10 days prior to symptom onset with a confirmed SARS-CoV case or a probable SARS-CoV case? * ** SEE APPENDIX B1 FOR CLASSIFICATION DEFINITIONS*	☐ Yes If yes, go to section 9, then return ☐ No ☐ Unknown
B. Close contact with a person considered an RUI-2 or RUI-3? * ** SEE APPENDIX B1 FOR CLASSIFICATION DEFINITIONS*	☐ Yes If yes, go to section 9, then return ☐ No ☐ Unknown

C. Travel to **foreign** or **domestic** area with documented or suspected recent local transmission of SARS cases? *(See list of areas at end of document)*

☐ Yes Enter Destination Below
☐ No
☐ Unknown

If yes to C, list travel destination(s) *(See list of areas at end of document)*

Destination: ______________________________

Date of Arrival: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Date of Departure: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Destination: ______________________________

Date of Arrival: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Date of Departure: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Destination: ______________________________

Date of Arrival: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Date of Departure: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Destination: ______________________________

Date of Arrival: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Date of Departure: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Contact History

9. Information on Ill Contacts

Add Contact information for ill contacts identified by question 8A or 8B above. These ill contacts should have been identified previously and have been given either a CDC or STATE ID. If an ID has not been given, enter contact name, but update when ID number is available.

Contact Information (1)

Contact CDC ID: ______________________ **OR** Contact STATE ID: ________________________

OR *(only if ID unavailable)* Name of Contact (first, middle initial, last):____

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Classification of Contact (SEE APPENDIX B1):	Nature of contact:	Contact Start:
□ RUI–2 □ RUI–3 □ Probable SARS CoV case □ Confirmed SARS CoV case	□ Same household □ Coworker □ Healthcare environment □ Other _____	__ __ / __ __ / __ __ __ __ m m d d y y y y Contact End: __ __ / __ __ / __ __ __ __ m m d d y y y y

Did the **ill contact** recently travel to an area with SARS transmission?
(see list of areas at end of document)

□ Yes
□ No
□ Unknown

If Yes, where? _____

Contact Information (2)

Contact CDC ID: _____ **OR** Contact STATE ID: _____

OR *(only if ID unavailable)* Name of Contact (first, middle initial, last): _____

Classification of Contact (SEE APPENDIX B1):	Nature of contact:	Contact Start:
□ RUI–2 □ RUI–3 □ Probable SARS CoV case □ Confirmed SARS CoV case	□ Same household □ Coworker □ Healthcare environment □ Other _____	__ __ / __ __ / __ __ __ __ m m d d y y y y Contact End: __ __ / __ __ / __ __ __ __ m m d d y y y y

Did the **ill contact** recently travel to an area with SARS transmission?
(see list of areas at end of document)

□ Yes
□ No
□ Unknown

If Yes, where? _____

Contact Information (3)

Contact CDC ID: _____ **OR** Contact STATE ID: _____

OR *(only if ID unavailable)* Name of Contact (first, middle initial, last): _____

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Classification of Contact (SEE APPENDIX B1):	Nature of contact:	Contact Start:
□ RUI-2 □ RUI-3 □ Probable SARS CoV case □ Confirmed SARS CoV case	□ Same household □ Coworker □ Healthcare environment □ Other _____	__ __ / __ __ / __ __ __ __ m m d d y y y y Contact End: __ __ / __ __ / __ __ __ __ m m d d y y y y
Did the **ill contact** recently travel to an area with SARS transmission? *(see list of areas at end of document)* *If Yes, where?* _____		□ Yes □ No □ Unknown

Travel History

10. Patient Travel Information			
If recent foreign travel, did the patient receive a **Health Alert** or other SARS educational information on arrival in the United States?			□ Yes □ No □ Unknown
Was the patient **symptomatic** during travel from a SARS affected area of within 24 hours of return to the US or local area?			□ Yes □ No □ Unknown
If yes: 1) Please provide to the CDC the name of the SARS suspect who has traveled *(enter name from section 3)*			
2) If yes, list all travel either by public conveyance (airplane, train bus) or with a tour group, 24 hours before onset of fever or symptoms and thereafter:			
List each portion or leg or the trip below:			
Trip or portion (1)			
Departure Date: __ __ / __ __ / __ __ __ __ m m d d y y y y	Departure City: _____	Arrival City: _____	Transport Type: □ Airline □ Auto □ Train □ Tour Group □ Cruise □ Other □ Bus
Transport Company:		Transport No:	
Comment:			
Trip or portion (2)			
Departure Date: __ __ / __ __ / __ __ __ __ m m d d y y y y	Departure City: _____	Arrival City: _____	Transport Type: □ Airline □ Auto □ Train □ Tour Group □ Cruise □ Other □ Bus

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Transport Company:	Transport No:		
Comment:			
Trip or portion (3)			
Departure Date: __ __ / __ __ / __ __ __ __ m m d d y y y y	Departure City: _____	Arrival City: _____	Transport Type: ☐ Airline ☐ Auto ☐ Train ☐ Tour Group ☐ Cruise ☐ Other ☐ Bus
Transport Company:	Transport No:		
Comment:			
Trip or portion (4)			
Departure Date: __ __ / __ __ / __ __ __ __ m m d d y y y y	Departure City: _____	Arrival City: _____	Transport Type: ☐ Airline ☐ Auto ☐ Train ☐ Tour Group ☐ Cruise ☐ Other ☐ Bus
Transport Company:	Transport No:		
Comment:			

(This page may be duplicated if needed)

Classification of Patient

11. Classification of patient by state of municipality (using CSTE/CDC definitions): SEE APPENDIX B1	
Initial Classification (check one only): *Report Under Investigation (RUI)* ☐ RUI–1 ☐ RUI–2 ☐ RUI–3 ☐ RUI–4 *OR SARS disease classification* ☐ Probable SARS–CoV Case ☐ Confirmed SARS–CoV Case	Updated Classification (check one only): ☐ RUI–1 ☐ RUI–2 ☐ RUI–3 ☐ RUI–4 ☐ Probable SARS–CoV Case ☐ Confirmed SARS–CoV Case ☐ Not a case: negative serology (>28 days post onset) ☐ Not a case: alternative diagnosis accounts for illness
	Date Updated (most recent): __ __ / __ __ / __ __ __ __ m m d d y y y y

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Laboratory Evaluation

12. Local SARS testing		
Chose from the following specimens to enter for each test: Whole blood, serum (acute), serum (convalescent), NP swab, NP aspirate, Broncheoalveolar lavage specimen, OP swab, urine, stool, tissue.		
Specimen 1		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ __ / __ __ / __ __ __ __ m m d d y y y y
Test Requested: □ PCR □ Convalescent serology □ Acute serology □ Culture	Source of Local Testing: □ Public Health Lab □ LRN □ Commercial lab □ other	Result: □ Positive □ Negative □ Pending □ Indeterminate
Specimen 2		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ __ / __ __ / __ __ __ __ m m d d y y y y
Test Requested: □ PCR □ Convalescent serology □ Acute serology □ Culture	Source of Local Testing: □ Public Health Lab □ LRN □ Commercial lab □ other	Result: □ Positive □ Negative □ Pending □ Indeterminate
Specimen 3		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ __ / __ __ / __ __ __ __ m m d d y y y y
Test Requested: □ PCR □ Convalescent serology □ Acute serology □ Culture	Source of Local Testing: □ Public Health Lab □ LRN □ Commercial lab □ other	Result: □ Positive □ Negative □ Pending □ Indeterminate

Specimen 4		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ __ / __ __ / __ __ __ __ m m d d y y y y
Test Requested: □ PCR □ Convalescent serology □ Acute serology □ Culture	Source of Local Testing: □ Public Health Lab □ LRN □ Commercial lab □ other	Result: □ Positive □ Negative □ Pending □ Indeterminate

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Specimen 5		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ __ / __ __ / __ __ __ __ m m d d y y y y
Test Requested: □ PCR □ Convalescent serology □ Acute serology □ Culture	Source of Local Testing: □ Public Health Lab □ LRN □ Commercial lab □ other	Result: □ Positive □ Negative □ Pending □ Indeterminate
Specimen 6		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ __ / __ __ / __ __ __ __ m m d d y y y y
Test Requested: □ PCR □ Convalescent serology □ Acute serology □ Culture	Source of Local Testing: □ Public Health Lab □ LRN □ Commercial lab □ other	Result: □ Positive □ Negative □ Pending □ Indeterminate
Specimen 7		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ __ / __ __ / __ __ __ __ m m d d y y y y
Test Requested: □ PCR □ Convalescent serology □ Acute serology □ Culture	Source of Local Testing: □ Public Health Lab □ LRN □ Commercial lab □ other	Result: □ Positive □ Negative □ Pending □ Indeterminate
Specimen 8		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ __ / __ __ / __ __ __ __ m m d d y y y y
Test Requested: □ PCR □ Convalescent serology □ Acute serology □ Culture	Source of Local Testing: □ Public Health Lab □ LRN □ Commercial lab □ other	Result: □ Positive □ Negative □ Pending □ Indeterminate

13. Alternative Diagnosis	
Was an alternative respiratory pathogen detected?	□ Yes □ No □ Unknown
If yes indicate which one (see list below): _____	

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Alternative pathogen (e.g., Influenza A, Influenza B, RSV, rhinovirus, adenovirus, *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Mycoplasma*, *Chlamydia pneumoniae*, human parainfluenza virus 1, human parainfluenza 2, human parainfluenza 3, human metapneumovirus, *Legionella* sp., other.):

14. List specimens sent to the CDC

Chose from the following specimens to enter below:
Whole blood, plasma, serum (acute), serum (convalescent), NP swab, NP aspirate, broncheoalveolar lavage specimen, OP swab, tracheal aspirate, pleural tap, urine, stool, tissue.

Specimen 1: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Specimen 2: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Specimen 3: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Specimen 4: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Specimen 5: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Specimen 6: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Specimen 7: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Specimen 8: _____	If 'Tissue', Specify: _____	Date Sent: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

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Notes

15. Notes:

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Note: List of areas with current confirmed or suspected SARS transmission

(If SARS-CoV transmission recurs, the list of foreign or domestic areas with documented or suspected recent local transmission of SARS–CoV will be listed here.)

Types of locations specified will vary (e.g., country, airport, city, building, floor of building). The last date a location may be a criterion for exposure for illness onset is 10 days (one incubation period) after removal of that location from CDC travel alert status. The patient's travel should have occurred on or before the last date the travel alert was in place. Transit through a foreign airport meets the epidemiologic criteria for possible exposure in a location for which a CDC travel advisory is in effect. Information regarding CDC travel alerts and advisories and assistance in determining appropriate dates are available at http://www.cdc.gov/ncidod/sars/travel.htm.

For more information, visit www.cdc.gov/ncidod/sars or call the CDC public response hotline at (888) 246-2675 (English), (888) 246-2857 (Español), or (866) 874-2646 (TTY)