

Hantavirus

Agency: _____

Investigator: _____

Phone number: _____

FOR STATE USE ONLY

Status: Confirmed Probable
 Suspect Not a case
Reviewer initials: _____
Referred to another state: _____

CASE

Last name: _____
First and middle name: _____
Maiden name: _____ Suffix: _____
Address line: _____
Zip: _____ City: _____
State: _____ County: _____
Phone: (____) - ____ - ____ Type: _____
Long-term care resident: Yes No Unknown
Facility name: _____

Date of Birth: ____ / ____ / ____ Estimated? Age: _____
Gender: Female Male Other _____
Pregnant: Yes No Unk Est. delivery date: ____ / ____ / ____
Marital status: Single Married Separated
 Divorced Parent with partner Widowed
Race: American Indian or Alaskan Native Unknown
 Black or African American White
 Hawaiian or Pacific Islander Asian
Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown
Parent/Guardian name: _____
Parent/Guardian phone: (____) - ____ - ____ Type: _____

EVENT

Diagnosis date: ____ / ____ / ____ Onset date: ____ / ____ / ____
 Survived this illness Died from this illness
Event outcome: Died unrelated to this illness Unknown
Date of death: ____ / ____ / ____
 Case could not be found
Event exception: Case could not be interviewed
 Case refused interview
 Other – see notes
Outbreak related: Yes No Unknown
Outbreak name: _____
Exposure setting: _____
Epi-linked: Yes No Unknown
Location acquired: In USA, in reporting state
 In USA, outside reporting state
 Outside USA
 Unknown
State: _____ Country: _____

Healthcare provider information

Last name: _____
First name: _____
Provider title: ARNP MD
 DO NP PA
Facility name: _____
Address line 1: _____
Address line 2: _____
Zip code: _____ City: _____
State: _____ County: _____
Phone: (____) - ____ - ____ Type: _____

LABORATORY FINDINGS

Laboratory: _____	Accession #: _____	Collection date: ____ / ____ / ____
Date received: ____ / ____ / ____	Specimen source: _____	Test type: _____
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____ / ____ / ____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism: _____		

Laboratory: _____	Accession #: _____	Collection date: ____ / ____ / ____
Date received: ____ / ____ / ____	Specimen source: _____	Test type: _____
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____ / ____ / ____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism: _____		

Laboratory: _____	Accession #: _____	Collection date: ____ / ____ / ____
Date received: ____ / ____ / ____	Specimen source: _____	Test type: _____
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____ / ____ / ____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism: _____		

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date worked from: _____ Date worked to: _____ Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date removed: _____	Job title: _____ Facility name: _____ Address: _____ Zip code: _____ City: _____ State: _____ County: _____ Phone: (____) - ____ - ____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Health care worker type: _____

Occupation type: Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date worked from: _____ Date worked to: _____ Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date removed: _____	Job title: _____ Facility name: _____ Address: _____ Zip code: _____ City: _____ State: _____ County: _____ Phone: (____) - ____ - ____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Health care worker type: _____

HOSPITALIZATIONS

Was the case hospitalized? Yes No Unknown

Hospital: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Isolation type (entry): _____
Admission date: ____ / ____ / ____	Discharge date: ____ / ____ / ____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____	

CLINICAL INFO & DIAGNOSIS

Fever: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset of fever date: ____ / ____ / ____	Highest known fever: ____ °F/C
Other Symptoms: <input type="checkbox"/> Fever <input type="checkbox"/> Hypotension <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Shock		
Chest X-ray done: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date of chest X-ray: ____ / ____ / ____	X-ray result: _____
Unexplained Bilateral Infiltrates on X-ray: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Oxygen saturation less than 90% at any time: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Tissue specimens available for testing: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
X-ray suggestive of RDS: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Respiratory compromise requiring oxygen: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		

Other explanations for acute illness: _____

OTHER LAB FINDINGS

Thrombocytopenia: Yes No Unk Elevated hematocrit: Yes No Unk Hypoalbuminaemia: Yes No Unk

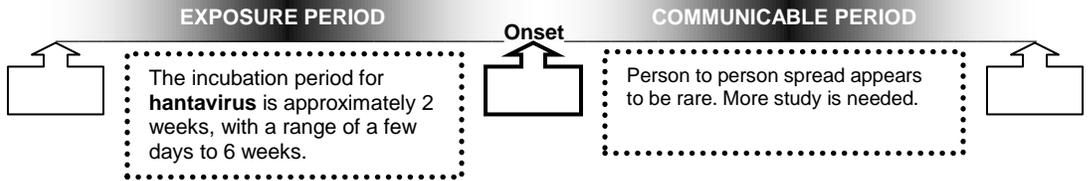
TREATMENT

For the illness, were any of the following treatments required?

Intubation: Yes No Unk Duration: _____ Hours Days **Respiratory assistance:** Yes No Unk Duration: _____ Hours Days
Oxygen: Yes No Unk **Ventilator:** Yes No Unk Duration: _____ Hours Days

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

In the 6 weeks prior to illness was the case:

Exposed to rodents/rodent droppings: Yes No Unknown Exposure date: ____ / ____ / ____ Rodent Type _____

State within US: _____ City within US: _____

NOTES:

Multiple horizontal lines provided for writing notes.