

# SARS

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: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Estimated?  Age: \_\_\_\_\_

Gender:  Female  Male  Other \_\_\_\_\_

Maiden name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Pregnant:  Yes  No  Unk Est. delivery date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address line: \_\_\_\_\_

Marital status:  Single  Married  Separated  
 Divorced  Parent with partner  Widowed

Zip: \_\_\_\_\_ City: \_\_\_\_\_

Race:  American Indian or Alaskan Native  Unknown  
 Black or African American  White  
 Hawaiian or Pacific Islander  Asian

State: \_\_\_\_\_ County: \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown

Facility phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Type: \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_

Long-term care resident:  Yes  No  Unknown

Parent/Guardian phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Type: \_\_\_\_\_

Facility name: \_\_\_\_\_

## EVENT

Diagnosis date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Onset date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Last name: \_\_\_\_\_

Event outcome:  Survived this illness  Died from this illness  
 Died unrelated to this illness  Unknown

First name: \_\_\_\_\_

Date of death: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Event exception:  Case could not be found  
 Case could not be interviewed  
 Case refused interview  
 Other – see notes

Provider title:  ARNP  MD  DO  NP  PA

Outbreak related:  Yes  No  Unknown

Outbreak name: \_\_\_\_\_

Facility name: \_\_\_\_\_

Exposure setting: \_\_\_\_\_

Address line 1: \_\_\_\_\_

Epi-linked:  Yes  No  Unk To whom: \_\_\_\_\_

Address line 2: \_\_\_\_\_

Location acquired:  In USA, in reporting state  
 In USA, outside reporting state  
 Outside USA  
 Unknown

Zip code: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Country: \_\_\_\_\_

Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Type: \_\_\_\_\_

Healthcare provider information

## LABORATORY FINDINGS

Laboratory: \_\_\_\_\_

Accession #: \_\_\_\_\_

Collection date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Specimen source: \_\_\_\_\_

Test type: \_\_\_\_\_

Result type:  Preliminary  Final

Result date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Result:  Positive  
 Negative

Organism: **SARS-CoV**

Laboratory: \_\_\_\_\_

Accession #: \_\_\_\_\_

Collection date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Specimen source: \_\_\_\_\_

Test type: \_\_\_\_\_

Result type:  Preliminary  Final

Result date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Result:  Positive  
 Negative

Organism: **SARS-CoV**

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: <b>SARS-CoV</b>		

**OCCUPATIONS**

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

*(If yes, complete the following sections for each known occupation)*

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

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

**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**

- Initial classification (select one):
- Severe respiratory illness with no known epi link
  - mild to moderate respiratory illness and epi link including possible SARS exposure
  - Severe respiratory illness and epi link including possible SARS exposure
  - Mild to moderate respiratory illness and epi link including likely SARS exposure
  - Severe respiratory illness and epi link including likely SARS exposure
  - Clinically compatible illness and laboratory confirmation of SARS-CoV

Fever:  Yes  No  Unk

Onset Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Duration: \_\_\_\_\_ hours/days

Highest known fever: \_\_\_\_\_ C/F

Other symptoms:  Chills  
 Cough

Diarrhea  
 Fever

Shortness of breath

Health care provider visited:  Yes  No  Unknown

If Yes, complete the following table:

Facility name: \_\_\_\_\_

Address: \_\_\_\_\_ Zip code: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_

Phone: ( )- - Type: \_\_\_\_\_ Date visited: / / Time visited: \_\_\_\_\_

Provider name: \_\_\_\_\_ Title: \_\_\_\_\_

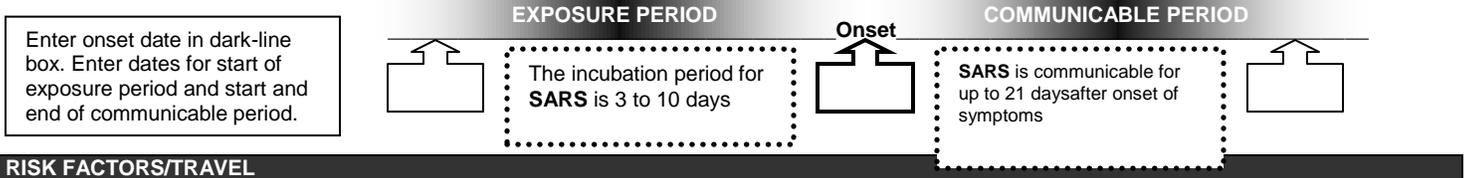
Chest x-ray done:  Yes  No  Unk Date: / / Result: \_\_\_\_\_

Pneumonia:  Yes  No  Unk Suggestive of RDS:  Yes  No  Unk

CAT scan done:  Yes  No  Unk Date: / / Result: \_\_\_\_\_

- Updated classification (select one):
- Severe respiratory illness with no known epi link
  - Mild to moderate respiratory illness and epi link including possible SARS exposure
  - Severe respiratory illness and epi link including possible SARS exposure
  - Mild to moderate respiratory illness and epi link including likely SARS exposure
  - Severe respiratory illness and epi link including likely SARS exposure
  - Clinically compatible illness and laboratory confirmation of SARS-CoV
  - Not a case: negative serology (> 28 days post onset)
  - Not a case: alternative diagnosis accounts for illness

**INFECTION TIMELINE**



**RISK FACTORS/TRAVEL**

**Risk Factors/Travel Information – In the 10 days prior to onset of symptoms:**

<p><b>Traveled within Iowa:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>City within Iowa: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Type: <input type="checkbox"/> Airline <input type="checkbox"/> Automobile <input type="checkbox"/> Bus <input type="checkbox"/> Cruise ship <input type="checkbox"/> Train</p> <p>Tour group: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Departure date: / /</p> <p>Return date: / /</p> <p>Company name: _____</p> <p>Transport #: _____</p> <p>Symptomatic during travel: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	<p><b>Traveled within Iowa:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>City within Iowa: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Type: <input type="checkbox"/> Airline <input type="checkbox"/> Automobile <input type="checkbox"/> Bus <input type="checkbox"/> Cruise ship <input type="checkbox"/> Train</p> <p>Tour group: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Departure date: / /</p> <p>Return date: / /</p> <p>Company name: _____</p> <p>Transport #: _____</p> <p>Symptomatic during travel: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>
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<p><b>Traveled within U.S.:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>City, State: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Type: <input type="checkbox"/> Airline <input type="checkbox"/> Automobile <input type="checkbox"/> Bus <input type="checkbox"/> Cruise ship <input type="checkbox"/> Train</p> <p>Tour group: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Departure date: / /</p> <p>Return date: / /</p> <p>Company name: _____</p> <p>Transport #: _____</p> <p>Symptomatic during travel: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	<p><b>Traveled within U.S.:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>City State: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Type: <input type="checkbox"/> Airline <input type="checkbox"/> Automobile <input type="checkbox"/> Bus <input type="checkbox"/> Cruise ship <input type="checkbox"/> Train</p> <p>Tour group: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Departure date: / /</p> <p>Return date: / /</p> <p>Company name: _____</p> <p>Transport #: _____</p> <p>Symptomatic during travel: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>
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<p><b>Travel outside U.S.:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>City Country: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Type: <input type="checkbox"/> Airline</p> <p>Departure date: / /</p> <p>Return date: / /</p> <p>Company name: _____</p>	<p><b>Traveled outside U.S.:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>City Country: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Type: <input type="checkbox"/> Airline <input type="checkbox"/> Automobile</p> <p>Departure date: / /</p> <p>Return date: / /</p> <p>Company name: _____</p>
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<input type="checkbox"/> Automobile <input type="checkbox"/> Bus <input type="checkbox"/> Cruise ship <input type="checkbox"/> Train Transport #: _____ Symptomatic during travel: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Bus <input type="checkbox"/> Cruise ship <input type="checkbox"/> Train Transport #: _____ Symptomatic during travel: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Tour group: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Tour group: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Contact with confirmed or probable SARS CoV case:  Yes  No  Unknown

Contact with epi-linked SARS CoV case:  Yes  No  Unknown

**CONTACTS**

Number of people living in case's household: \_\_\_\_\_

Are there close contacts of the case with similar symptoms:  Yes  No  Unknown

**Close contacts with similar symptoms**

Name	DOB	Gender	Address/Phone
_____	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ Zip code: _____ Phone: _____-____-____
Relationship to case	List symptoms		Symptom onset date
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Roommate <input type="checkbox"/> Parent/ guardian	<input type="checkbox"/> Sexual contact <input type="checkbox"/> Family member (non-household) <input type="checkbox"/> Friend/acquaintance <input type="checkbox"/> Contact- work/school/etc <input type="checkbox"/> Unknown/Other	_____	____/____/____
			<input type="checkbox"/> Yes <input type="checkbox"/> No

*If this contact is a case create a new event and/or case for this contact.* ←

Did the case recently travel to an area with SARS transmission?  Yes  No  Unknown **If yes, where:** \_\_\_\_\_

Name	DOB	Gender	Address/Phone
_____	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ Zip code: _____ Phone: _____-____-____
Relationship to case	List symptoms		Symptom onset date
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Roommate <input type="checkbox"/> Parent/ guardian	<input type="checkbox"/> Sexual contact <input type="checkbox"/> Family member (non-household) <input type="checkbox"/> Friend/acquaintance <input type="checkbox"/> Contact- work/school/etc <input type="checkbox"/> Unknown/Other	_____	____/____/____
			<input type="checkbox"/> Yes <input type="checkbox"/> No

*If this contact is a case create a new event and/or case for this contact.* ←

Did the case recently travel to an area with SARS transmission?  Yes  No  Unknown **If yes, where:** \_\_\_\_\_

Name	DOB	Gender	Address/Phone
_____	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ Zip code: _____ Phone: _____-____-____
Relationship to case	List symptoms		Symptom onset date
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Roommate <input type="checkbox"/> Parent/ guardian	<input type="checkbox"/> Sexual contact <input type="checkbox"/> Family member (non-household) <input type="checkbox"/> Friend/acquaintance <input type="checkbox"/> Contact- work/school/etc <input type="checkbox"/> Unknown/Other	_____	____/____/____
			<input type="checkbox"/> Yes <input type="checkbox"/> No

*If this contact is a case create a new event and/or case for this contact.* ←

Did the case recently travel to an area with SARS transmission?  Yes  No  Unknown **If yes, where:** \_\_\_\_\_

Notes:

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**State use only**

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

13. Alternative Diagnosis
Was an alternative respiratory pathogen detected? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  If yes indicate which one (see list below): _____  Alternative pathogen (e.g., Influenza A, Influenza B, RSV, rhinovirus, adenovirus, <i>Streptococcus pneumoniae</i> , <i>Haemophilus influenzae</i> , <i>Mycoplasma</i> , <i>Chlamydia pneumoniae</i> , human parainfluenza virus 1, human parainfluenza 2, human parainfluenza 3, human metapneumovirus, <i>Legionella</i> 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, bronchoalveolar 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