

CALIFORNIA CASE REPORT FORM FOR SARS-LIKE ILLNESS

Date of Initial report to LHD: ____/____/____ CDC ID#: _____ CDHS ID#: _____ Revised 1/13/04

Fax to: 510-540-2570

Section 1. Patient Information

Patient's Last Name: _____ First Name _____ MI: _____

Current Street Address: _____

Current Residence: City: _____ State: _____ County: _____

Home telephone _____ Work telephone _____

Age at onset: _____ Years Months Gender: Male Female

Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino

Race: Native American/Alaskan Native Asian Pacific Islander
 African American/Black White Other Unk

Nationality/Citizenship: _____ Residency: U.S. Resident Non-U.S. Resident

Patient Occupation: Physician Nurse/PA Laboratory
 Resp. therapist Radiology tech Other _____

If Health care worker (HCW), place of employment: Hospital Long Term Care Facility Ambulatory care
 Clinical laboratory Other _____

If HCW, name(s) of place(s) of employment, and dates worked, in the 10 days prior to symptom onset (list all that apply) _____

If HCW, does patient have DIRECT patient care responsibilities? Yes No Unk

Section 2. Signs and Symptoms

Date of Initial Symptom Onset: ____/____/____

Did the person have a fever (subjective or objective)? Yes No Unk

If yes, date of fever onset: ____/____/____

If yes, was temperature >38° C (>100.4° F)? Yes No Unk

Other early symptoms (to determine RUI-4): chills rigors myalgia headache diarrhea sore throat rhinorrhea

Did the patient have any lower respiratory symptoms (e.g. cough, shortness of breath, difficulty breathing)? Yes No Unk

If yes, date of respiratory onset: ____/____/____

Was the patient hypoxic? Yes No Unk Date of test: ____/____/____

If yes, what was the first O₂ saturation? _____%

Was a chest X-ray performed? Yes No Unk If yes, date: ____/____/____

If yes, was there evidence of pneumonia or respiratory distress syndrome? Yes No Unk

Interpretation: _____

Was a CAT scan performed? Yes No Unk If yes, date: ____/____/____

If yes, was there evidence of pneumonia or respiratory distress syndrome? Yes No Unk

Interpretation: _____

Comments:

Section 3. Clinical Status

Date of first clinical evaluation for this illness: ____/____/____

Was the patient hospitalized for >24 hours during this course? Yes No Unk

If yes: Name of hospital: _____

City: _____ State: _____

Date of admission: ____/____/____ Date of discharge: ____/____/____

Was the patient transferred to or from another facility? Yes No Unk

If yes, facility name: _____

If yes, Date of transfer: ____/____/____

Was the patient ever in the ICU? Yes No Unk

Was the patient ever placed on mechanical ventilation? Yes No Unk

Did patient die as a result of this illness? Yes No Unk

If yes, date of death: ____/____/____

If yes, Was an autopsy performed? Yes No Unk

If yes, Was the pathology consistent with pneumonia or RDS? Yes No Unk

Section 4. SARS Epidemiological Risk Factors

Risk questions, in the absence of person-to-person SARS transmission (Level 0):

1. In the 10 days prior to symptom onset, did the patient travel to (or become exposed to ill travelers from) Hong Kong, China, or Taiwan? Yes No Unk (If YES to exposure to ill traveler, please fill out source case information in SECTION 10)

2. Is the patient a HCW or does the patient work in another high risk occupation such as in a laboratory which contains live SARS-CoV?* Yes No Unk *A HCW is defined as a person who has close contact to patients, patient care areas (e.g., patient rooms), or patient care items (e.g., linens, patient specimens)

3. Is the patient a close contact to an identified pneumonia cluster or person with unexplained pneumonia? Yes No Unk (If YES, please fill out source case information in SECTION 10)

Additional risk questions, asked only in the presence of person-to-person SARS transmission (Level 1):

If YES to any of the following close contact questions, please fill out SECTION 10

In the 10 days prior to symptom onset, did the patient have the following:

A. Close contact to a laboratory-confirmed SARS case or an ill person whose chain of transmission is linked to a confirmed case? Yes No Unk

B. Travel to foreign or domestic location with recent documented or suspected local transmission of SARS? Yes No Unk

If yes, which area(s)? _____

If yes, was the patient symptomatic during travel from a SARS affected area or within 24 hours of return to the U.S. or local area? Yes No Unk

C. Close contact to a person with respiratory illness who traveled to areas in question B (above)? Yes No Unk

D. Close contact with a person considered a RUI-2 or RUI-3 SARS case? Yes No Unk

For patients hospitalized with pneumonia who answer No to All Level 1 risk questions, please ask risk questions for Level 0 and follow the algorithm for evaluating, managing, and reporting patients with fever or respiratory symptoms in the presence of known SARS activity anywhere in the world.

Complete if travel to foreign or domestic area with documented or suspected recent local transmission of SARS cases. **List each portion or leg of the trip in the space below.** Copy or use additional pages if necessary.

Leg 1
Departure Date: ____/____/____ **Departure City:** _____ **Arrival City:** _____ **Arrival Date:** ____/____/____
Transport type: Airline Train Auto Cruise Bus Tour group Other _____
Transport company: _____ **Transport number:** _____

Leg 2
Departure Date: ____/____/____ **Departure City:** _____ **Arrival City:** _____ **Arrival Date:** ____/____/____
Transport type: Airline Train Auto Cruise Bus Tour group Other _____
Transport company: _____ **Transport number:** _____

Leg 3
Departure Date: ____/____/____ **Departure City:** _____ **Arrival City:** _____ **Arrival Date:** ____/____/____
Transport type: Airline Train Auto Cruise Bus Tour group Other _____
Transport company: _____ **Transport number:** _____

If foreign travel, did patient receive a Health Alert or other SARS information on arrival to the U.S.? Yes No Unk

Section 6. Local Hospital/Outpatient Laboratory Results

Date of first specimen collection: ____/____/____

Blood culture: Not done Neg Pos Organism isolated: _____ Collection Date: ____/____/____

Sputum culture: Not done Neg Pos Organism isolated: _____ Collection Date: ____/____/____

Rapid influenza test: Not done Negative Positive Collection Date: ____/____/____

Rapid RSV test: Not done Negative Positive Collection Date: ____/____/____

S. pneumoniae urine antigen: Not done Negative Positive Collection Date: ____/____/____

Legionella urine antigen: Not done Negative Positive Collection Date: ____/____/____

Legionella DFA: Not done Negative Positive Collection Date: ____/____/____

Legionella serology: Not done Negative Positive Collection Date: ____/____/____

Other Tests: Test: _____ Result: _____ Collection Date: ____/____/____
 Test: _____ Result: _____ Collection Date: ____/____/____

Section 7. Alternative Diagnosis

Was an alternative respiratory pathogen detected for the patient? Yes No Unk

If yes, indicate which pathogen(s): _____

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

Section 8. Submitted By

Last Name: _____ First Name: _____ Phone: (____) _____

Affiliation: _____ County: _____ E-mail: _____

Section 9. Initial and Updated Classification of Case

Initial Classification (check only one)
Reports in persons from areas where SARS is not known to be active
 RUI-1 (severe illness compatible with SARS in groups likely to be first affected by SARS who answer YES to any of the LEVEL 0 questions)
Reports in persons from areas where SARS activity is occurring
 RUI-2 (mild to moderate illness and possible exposure to SARS)
 RUI-3 (severe illness and possible exposure to SARS)
 RUI-4 (early or mild to moderate illness and likely exposure to SARS)
SARS – CoV Disease Classification
 Probable SARS-CoV (severe respiratory illness and likely exposure to SARS)
 Confirmed SARS-CoV (clinically compatible illness/laboratory confirmed)

Updated Classification (check only one) ____/____/____
Reports in persons from areas where SARS is not known to be active
 RUI-1 (severe illness compatible with SARS in groups likely to be first affected by SARS who answer YES to any of the LEVEL 0 questions)
Reports in persons from areas where SARS activity is occurring
 RUI-2 (mild to moderate illness possible exposure to SARS)
 RUI-3 (severe illness and possible exposure to SARS)
 RUI-4 (early or mild to moderate illness and likely exposure to SARS)
SARS – CoV Disease Classification
 Probable SARS-CoV (severe respiratory illness and likely exposure to SARS)
 Confirmed SARS-CoV (clinically compatible illness/laboratory confirmed)
 Not a case – does not meet case definition
 Not a case - negative serology (>28 days post onset)
 Not a case - alternative diagnosis

FOR STATE USE ONLY
 Under Investigation – Initial Classification (following up on case, but not currently sending to CDC)
 Under Investigation – Updated Classification (lost to follow-up)
 Special Interest - Updated Classification (reported to CDC, but not in final counts)

Section 10. Source Case Information

This section should be filled out if the patient reported any close contact to **a)** an ill traveler from Hong Kong, China, or Taiwan, **b)** a cluster or case of unexplained pneumonia, **c)** a confirmed SARS case or an ill person epidemiologically linked to a confirmed case, **d)** a person with respiratory illness who has traveled to a foreign or domestic location with recent documented or suspected local transmission of SARS, or **e)** a person considered a suspect or probable SARS case.
 Please complete this page and submit with the current case report form so we can link ill contacts with each other.

Because the source case also has at least one risk factor and is thus reportable, please be sure to submit a case report form for the source case as well. If the source case is not a resident of your county or not a California resident, please collect as much information as possible about the source case and contact a member of the state SARS team so they may contact appropriate individuals for follow-up.

If the patient lists more than two possible source cases, please use additional pages or space below.

Source Case 1:

Name: _____
Address: _____
City: _____ **County:** _____ **State:** _____
Telephone (h): (____) _____ **Telephone (w):** (____) _____
Nature of Contact: Household Co-worker Health care Other
Please describe the nature of the contact:

Date of patient's last exposure to source case: ____/____/____
Has a case report form been completed on source case? Yes No Unk In Progress
 If yes, date of completion: ____/____/____
 If known, source case's CDC ID# _____ CDHS# _____ Local ID# _____

Source Case 2:

Name: _____
Address: _____
City: _____ **County:** _____ **State:** _____
Telephone (h): (____) _____ **Telephone (w):** (____) _____
Nature of Contact: Household Co-worker Health care Other
Please describe the nature of the contact:

Date of patient's last exposure to source case: ____/____/____
Has a case report form been completed on source case? Yes No Unk In Progress
 If yes, date of completion: ____/____/____
 If known, source case's CDC ID# _____ CDHS# _____ Local ID# _____

Section 11. Contact Information

In contrast to source case information, contact information in this section refers to those individuals the patient has had contact with **since** becoming ill. Unless otherwise specified, CDHS will not routinely request the information you collect on "trace-forward" contacts. If you would like to consult with a member of the SARS team at CDHS, please call Gillian Hamilton, Kate Cummings, or Jon Rosenberg, at 510-540-2566.

Section 12. Additional Comments