Version 4-29-03 12 pm

Form Approved
OMB No. 0920-0008
Exp. Date _____

SARS Report Intake Form **CDC ID#**

1. Name/affiliation of person filling out form				STATE ID # (***if any)***			
Date of Report:	MM	DD	2003	**Time of Report:**	:	AM PM	

2. State Health Department Contact	Last Name:	First Name:	**State:**		
Phone: ( )	Pager: ( )	Other ( )	☐ Phone ☐ Fax	Other ( )	☐ Phone ☐ Fax
If reporter is not from State Health Department, has HD been notified?	☐ Yes ☐ No ☐ N/A	Notified by EOC? ☐ Yes Date:			

3. Reporter or Clinician Contact	Last Name:	First Name:			
Hospital or Clinic Name:			City:		
County/Borough:	State:		ZIP:		
Phone: ( )	Pager: ( )	Other ( )	☐ Phone ☐ Fax	Other ( )	☐ Phone ☐ Fax

4. Patient Information	Last Name:	First Name:			
City of residence:	County/Boro of residence:	State of Residence:	ZIP:	Country:	
Phone 1: ( )	☐ Patient ☐ Other	Phone 2: ( )	☐ Patient ☐ Other		
Date of Birth: MM DD YYYY	Age _____	☐ Years ☐ Months	Sex	☐ Male ☐ Female	
Is the patient pregnant now?	☐ Yes ☐ No ☐ Don't Know	Expected Delivery Date: ___ / ___ / ____	Is the patient breast feeding now?	☐ Yes ☐ No	
Ethnicity: ☐ Hispanic ☐ Non-Hispanic	Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ Native Hawaiian /Other Pacific Islander ☐ White ☐ Other: _____				
Nationality: _____	Residency:	☐ U.S. Resident ☐ Non-U.S. Resident			

5. Occupation	Healthcare worker?	☐ Yes ☐ No	***If yes, specify*** ☐ Physician ☐ Nurse/PA ☐ Laboratory ☐ **Other:** _____
If ***not a*** healthcare worker, list occupation:			

Patient Name: _____ **CDC ID #:** _____

6. Signs and Symptoms	Date of symptom onset:	MM	DD	YYYY
	Date of fever onset:	MM	DD	YYYY

Check all signs and symptoms that apply

Measured Temperature?	□ Yes □ No	If no, was an unmeasured Temperature reported?			□ Yes □ No
□ Measured Temperature > 38°C (100.4°F)	Highest Measured Temperature _____	□°C □°F	□ Cough	□ Shortness of breath/ difficulty breathing	
□ Hypoxia (Room air O_2 saturation < 94%)		□ Respiratory Distress Syndrome—(ARDS)			

□ Other symptoms or relevant findings, List:

7. Clinical status at the time of report	□ Outpatient □ Emergency Room □ Inpatient □ Died □ Left Against Medical Advice □ Transferred to Another Facility □ Unknown

Date of first health care evaluation for this illness: ___ / ___ / _____	Date of this health care evaluation: ___ / ___ / _____

Was patient hospitalized for > 24 hours during course? □ Yes □ No □ Unknown

Was patient admitted to the intensive care unit (ICU)?	□ Yes □ No □ Unknown	Is patient currently in ICU?	□ Yes □ No □ Unknown
Was patient placed on mechanical ventilation?	□ Yes □ No □ Unknown	Is patient currently on mechanical ventilator?	□ Yes □ No □ Unknown

Date of Hospitalization:	MM	DD	YY	**Date of Discharge or Death**	MM	DD	YY

Name of Hospital:	**City:**	**State:**	**Phone number:**

***If transferred,* Date of transfer:**	MM	DD	YY	**Date of Discharge or Death from receiving hospital**	MM	DD	YY

Name of Receiving Hospital:	**City:**	**State:**	**Phone number:**

Did the patient **donate** blood or plasma:

a. in the 14 days before fever or respiratory symptoms began?	□ Yes □ No □ Don't Know	b. while symptomatic or in the 28 days after symptoms stopped?	□ Yes □ No □ Don't Know
Did the patient receive a blood transfusion in the 14 days before fever or respiratory symptoms began?			□ Yes □ No □ Don't Know

If patient died: Was an autopsy performed?	□ Yes □ No □ Unknown	Was pathology consistent with Respiratory Distress Syndrome?	□ Yes □ No □ Unknown

What was the cause of death based on autopsy? _____ □ Unknown

Patient Name: _____ **CDC ID #:** _____

8. Diagnostic evaluation:	Was a chest X-Ray performed?	□ Yes □ No □ Don't Know

□ Radiographic findings of pneumonia - Lobar consolidation
□ Positive □ Negative □ Pending **Comment/Result:**_____

□ Radiographic findings of pneumonia - Interstitial infiltrate
□ Positive □ Negative □ Pending **Comment/Result:**_____

□ Radiographic findings of pneumonia - Pleural effusion
□ Positive □ Negative □ Pending **Comment/Result:**_____

□ Radiographic findings of pneumonia - ARDS
□ Positive □ Negative □ Pending **Comment/Result:**_____

□ Radiographic findings of pneumonia - Other: _____
□ Positive □ Negative □ Pending **Comment/Result:**_____

□ Blood culture(s) □ Positive □ Negative □ Pending **Comment/Result:**_____

□ Sputum gram stain □ Positive □ Negative □ Pending **Comment/Result:**_____

□ Rapid Influenza test □ Positive □ Negative □ Pending **Comment/Result:**_____

□ Respiratory Syncytial Virus □ Positive □ Negative □ Pending **Comment/Result:**_____

□ Lowest **WBC** Count: _____ □ Lowest **Platelet** Count: _____

□ Convalescent Serum Due Date ___ / ___ / _____ | Date Specimen Collected ___ / ___ / _____

Other pertinent diagnostic tests:

□ Test _____ □ Positive □ Negative □ Pending **Comment/Result:**_____

□ Test _____ □ Positive □ Negative □ Pending **Comment/Result:**_____

□ Test _____ □ Positive □ Negative □ Pending **Comment/Result:**_____

Has an etiology for patient's illness been determined? ***If yes***: list: _____	□ Yes □ No

9. Travel History	Did patient travel to any the following destinations within 10 days of symptom onset? □ Yes, ***specify below*** □ No □ Unknown travel history								
1. Hanoi, Vietnam	□ Yes □ No □ Unk	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
2. Singapore	□ Yes □ No □ Unk	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
3. Toronto, Canada	□ Yes □ No □ Unk	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
4. Taiwan	□ Yes □ No □ Unk	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
5. China, mainland	□ Yes □ No □ Unk	If Yes, specify which locations in sections 1a.-1gg. If No or Unk, please skip to section 2.							
a. □ Anhui Province, PRC		**DATES** From:	MM	DD	YY	To:	MM	DD	YY

Patient Name: _____ **CDC ID #:** _____

b. ☐ Beijing city	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
c. ☐ Chongqing city	**DATES** From:	MM	DD	YY	To:		DD	YY
d. ☐ Fujian Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
e. ☐ Gansu Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
f. ☐ Guizhou Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
g. ☐ Guangdong Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
h. ☐ Guangxi Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
i. ☐ Hainan Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
j. ☐ Hebei Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
k. ☐ Heilongjiang Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
l. ☐ Henan Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
m. ☐ Hong Kong city	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
n. ☐ Hubei Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
o. ☐ Hunan Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
p. ☐ Jiangsu Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
q. ☐ Jiangxi Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
r. ☐ Jilin Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
s. ☐ Liaoning Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
t. ☐ Macao city	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
u. ☐ Inner Mongolia (Nei Mongol) Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
v. ☐ Ningxia Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
w. ☐ Qinghai Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
x. ☐ Shanxi Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
y. ☐ Shandong Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY

z. ☐ Shanghai city	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
aa. ☐ Shanxi Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
bb. ☐ Sichuan Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
cc. ☐ Tianjin city	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
dd. ☐ Tibet (Xizang) Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
ee. ☐ Xinjiang Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
ff. ☐ Yunnan Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
gg. ☐ Zhejiang Province, PRC	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
6. ☐ Other _____ City/State/Country	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
7. ☐ Other _____ City/State/Country	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
8. ☐ Other _____ City/State/Country	**DATES** From:	MM	DD	YY	To:	MM	DD	YY

Purpose(s) of trip and activities: ☐ Business ☐ Visit Family/Friends ☐ Vacation ☐ Other

Did patient travel with a group or a group tour? *If yes, give the contact information for the group organizer below:*	☐ Yes ☐ No ☐ Unknown

Name of group or organization:	Name of contact person in charge:

Contact Phone: ( )	Contact Fax: ( )	Contact Email:

Please answer following questions only if patient spent time in Hong Kong (including only airline transfers):

Did patient overnight or have a day room in a hotel in Hong Kong?	☐ Yes ☐ No ☐ Unknown

At which hotel did patient overnight or have a day room in Hong Kong?

Dates of hotel contact: ____/____/_____ to ____/____/_____	Nights spent in hotel:	Floor(s) of hotel visited:	Room number(s):

Did patient ever go into the Metropole Hotel for any reason?
☐ Yes, ***specify below*** ☐ No ☐ Don't know

If yes, please describe what patient did in the hotel?

Did the patient share any form of transportation with persons that patient knew where Metropole Hotel guests?
☐ Yes, ***specify below*** ☐ No ☐ Don't know

If **yes**, please describe the circumstances:

Patient Name: _____ **CDC ID #:** _____

10. Flight History	*List all travel by plane or ship in the 10 days before onset:*				
Date?	Departure Location?	Arrival Location?	Cruise Line?	Airline?	Flight #?

Did the patient receive a yellow card as they disembarked from their return flight from Asia instructing them to seek medical evaluation if they became ill? ☐ Yes ☐ No ☐ Unknown

11. Contact history

In the 10 days prior to onset of symptoms, did the patient have close contact with any person with respiratory illness and travel to the areas mentioned above? ***If yes, give contact information below*** ☐ Yes ☐ No ☐ Unknown

In the 10 days prior to onset of symptoms, did the patient have close contact with any person under investigation for SARS? ***If yes, give contact information below*** ☐ Yes ☐ No ☐ Unknown

Contact Last: First: CDC ID# ☐ Household ☐ Healthcare worker ☐ Other __________ Contact Date Initial ___ / ___ / ____ End ___ / ___ / ____

Did contact travel to area with SARS transmission? ☐ Yes ☐ No ☐ Unknown ***If yes, where?*** ____________________

Contact Last: First: CDC ID# ☐ Household ☐ Healthcare worker ☐ Other __________ Contact Date Initial ___ / ___ / ____ End ___ / ___ / ____

Did contact travel to area with SARS transmission? ☐ Yes ☐ No ☐ Unknown ***If yes, where?*** ____________________

Contact Last: First: CDC ID# ☐ Household ☐ Healthcare worker ☐ Other __________ Contact Date Initial ___ / ___ / ____ End ___ / ___ / ____

Did contact travel to area with SARS transmission? ☐ Yes ☐ No ☐ Unknown ***If yes, where?*** ____________________

12. FOR CDC use only :

Notes:

Completed forms should be faxed to the CDC Emergency Operations Center at 770-488-7107.

Patient Name: ________________________ **CDC ID #:** ___________________________