Form Approved
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Exp. Date _____

**DEPARTMENT OF HEALTH & HUMAN SERVICES** Public Health Service

Centers for Disease Control and Prevention (CDC)
Atlanta GA 30333

**Version 3-27-03 12:00**

# International SARS Case Report Form

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **1. Name/affiliation of person filling out form** | | | | Patient ID # ***(if any)*** | | | |
| **Date of Report:** | MM | DD | 2003 | **Time of Report:** | : | AM☐ PM☐ | |
| **2. Followup Contact Information** | Last Name: | | First Name: | | **Country:** | | |
| Phone: ( ) | Email: | Other ( ) | ☐ Phone ☐ Fax | Other ( ) | ☐ Phone ☐ Fax | | |
| **3. Reporter or Clinician Contact** | Last Name: | | First Name: | | | | |
| Hospital or Clinic Name: | | | | City: | | | |
| Country | Province: | | | | | | |
| Phone: ( ) | Email: | Other ( ) | ☐ Phone ☐ Fax | Other ( ) | ☐ Phone ☐ Fax | | |
| **4. Patient Information** | Last Name: | | First Name: | | | | |
| City of residence: | Province of residence: | Country of Residence: | Nationality: _____ | | | | |
| Date of Birth: MM | DD | YYYY | Age _____ | ☐ Years ☐ Months | Sex ☐ Male ☐ Female | | |
| **5. Occupation** | Healthcare worker? ☐ Yes ☐ No | ***If yes, specify*** ☐ Physician ☐ Nurse/PA ☐ Laboratory ☐ **Other:** _____ | | | | | |
| ***If not a healthcare worker***, list occupation: | | | | | | | |
| **6. Signs and Symptoms** | Date of symptom onset | MM | DD | YYYY | | | |
| **Check all signs and symptoms that apply** | | | | | | | |
| ☐ Temperature > 38°C (100.4°F) | Highest Temperature _____ | ☐°C ☐°F | ☐ Cough | ☐ Shortness of breath/ difficulty breathing | | | |
| ☐ Pneumonia ☐ Radiographic evidence of Pneum. | ☐ Respiratory Distress Syndrome—(ARDS) | | | | | | |
| ☐ Other symptoms or relevant findings, ***List:*** | | | | | | | |
| **7. Clinical status at the time of report** | ☐ Outpatient ☐ Discharged ☐ Inpatient ☐ Died ☐ Unknown | | | | | | |
| Was Patient Hospitalized? | ☐ 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:** | **Country:** | **Phone number:** | | | | |

| | | | |
|---|---|---|---|
| ***If patient died:*** Was an autopsy performed? | ☐ Yes<br>☐ No<br>☐ Unk | Was pathology consistent with Respiratory Distress Syndrome? | ☐ Yes<br>☐ No<br>☐ Unk |

Was pathology consistent with Respiratory Distress Syndrome?

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

**8. Diagnostic evaluation:** Has an etiology for patient's illness been determined? ☐ Yes ☐ No
***If yes***: list: _____

***Please fill in results of any tests that have been performed at this time:***

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

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

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

☐ Resp Sync Virus ☐ Positive ☐ Negative ☐ Pending **Comment/Result:** _____

**9. Other pertinent clinical information and laboratory tests:**

☐ Lowest **WBC** Count: _____ ☐ Lowest **Platelet** Count: _____

☐ Highest **CPK** : _____ ☐ Lowest Absolute lymphoctye count : _____

☐ Highest **AST** : _____

☐ Highest **ALT** : _____

**Needed Supplemental Oxygen?** ☐ Yes ☐ No

**10. Travel History** Did patient travel to any the following destinations within 10 days of symptom onset?
☐ Yes, ***specify below*** ☐ No ☐ Unknown travel history

☐ Hong Kong
☐ Guangdong Province, People's Rep. of China
☐ Hanoi, Vietnam
☐ Singapore
☐ Toronto, Canada
☐ Other _____ City/State/Country

| | | |
|---|---|---|
| **11. Exposure History** | Indicate if the patient was one or more of the following : | ☐ Health Care worker<br>☐ Household Contact of SARS Case<br>☐ Friend of SARS Case<br>☐ Guest at a hotel where other SARS patients stayed<br>☐ Other ☐ Unknown |

Notes: (Dates of contact with SARS patients if known)

**12. FOR CDC use only : Meets Suspect Case Definition:** ☐ Yes ☐ No **CDC ID#**

*Completed forms should be faxed to the CDC Emergency Operations Center at 1-770-488-7107.*