Version 04-29-03

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

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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:

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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 #:** ___________________________