Viral Special Pathogens Branch Diagnostic Specimen Submission Form

• Hantavirus Pulmonary Syndrome (HPS)* and other hantaviruses	☐	• Tick-borne Encephalitis	☐
• Ebola HF*	☐	• Lymphocytic choriomeningitis (LCM)	☐
• Marburg HF*	☐	• Hemorrhagic Fever with Renal Syndrome (HFRS)	☐
• Lassa Fever*	☐	• Rift Valley Fever	☐
• Crimean-Congo hemorrhagic fever (CCHF)*	☐	• Other hemorrhagic fevers: _____	☐

PLEASE COMPLETE ONE FORM PER PATIENT

** indicates a Notifiable Disease*

*** Please check off boxes to indicate testing request(s).***

PATIENT NAME:	Patient ID no.:
DOB:	DATE OF SYMPTOM ONSET:
CLINICAL DESCRIPTION:	

No.	Specimen ID No.	State Lab ID No.	Date collected	Specimen type
1				
2				
3				
4				
5				

FOR STATE HEALTH DEPARTMENTS	
Report/send results to: Person's name: Affiliation:	Phone no., fax no., and email address:
State Health Lab:	Phone no. and email address:
Person shipping specimen(s): Affiliation:	Phone no. and email address:
Physician's name: Affiliation:	Phone no. and email address:
State health department contact:	Phone no. and email address:
	Airway bill # (if known):

Instructions: You must have internet access and an email address to submit this Form electronically. Upon hitting the 'Send to CDC' button, a PDF is created, attached to an email, which you should then send to the address which appears in the address header; you may also cc: others. Acknowledgement of receipt by CDC is not provided. To print this form in order to fax or mail it, be sure to Save this form first.

SEND TO CDC

For hantavirus/HPS, be sure to provide a copy of this Form to your state Health Department.

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
ATLANTA, GA 30329

Form Approved OMB No. 0920-0009

Hantavirus Disease Case Report Form

Please return to: Centers for Disease Control and Prevention, Viral Special Pathogens Branch
Ph: (404) 639-1510 Fax: (404) 639-3163 Email: spath_er@cdc.gov
Site: http://www.cdc.gov/hantavirus/health-care-workers/specimen-submission/index.html

Patient Identification

_____

-FIPS- _____ -YR- _____

Information below is required for identification and meaningful interpretation of laboratory diagnostic results. Hantavirus disease may not be confirmed without compatible clinical and/or exposure data.

PATIENT INFORMATION

Last name: _____

First name: _____ MI: _____

Age: _____ Sex: _____

City/town: _____

County: _____

State: _____ ZIP: _____

Choose one (if known):

☐ Hantavirus (Cardio) Pulmonary Syndrome
☐ Non-pulmonary Hantavirus Disease

PATIENT'S BACKGROUND AND EXPOSURE INFORMATION

Occupation: _____

Ethnicity: _____

Race *(Check all that apply)*:
☐ American Indian/Alaska Native:
☐ Asian ☐ Black or African American
☐ White ☐ Native Hawaiian/other Pacific Islander

History of rodent exposure 8 weeks prior to illness onset? ☐ Yes ☐ No

If yes, type of rodent exposure: _____

Place of contact (town, county, state): _____

Exposure occurred while *(Check all that apply)*:

☐ Cleaning ☐ Working ☐ Recreational activity (camping, hiking) ☐ Other (explain below)

Additional information about exposure:

TIMELINE

Date symptom onset: _____

Was patient hospitalized? ☐ Yes ☐ No

Date of admission: _____

Date of discharge: _____

PRE-HOSPITAL TREATMENT

Did patient seek care before admission?
☐ Yes ☐ No

Date: _____

Outcome *(sent home, diagnosed as flu, etc)*:

CLINICAL INFORMATION

Fever > 101F (38.3C)? ☐ Yes ☐ No
Thrombocytopenia? (<150,000) ☐ Yes ☐ No
Elevated hematocrit (> 50%) ☐ Yes ☐ No
Elevated creatinine (> 1.2 mg/dL) ☐ Yes ☐ No

HOSPITAL COURSE

Supplemental oxygen required? ☐ Yes ☐ No
Was patient on ECMO? ☐ Yes ☐ No
Was patient intubated? ☐ Yes ☐ No
CXR with unexplained bilateral interstitial infiltrates or suggestive of ARDS? ☐ Yes ☐ No

Notes on clinical course of illness:

OUTCOME

Outcome of illness: _____

Date of death: _____

Autopsy performed? ☐ Yes ☐ No

Autopsy findings:

SPECIMEN INFORMATION

Collection date: _____

Type of specimen: _____

If specimen tested, at which laboratory?

_____

Results (i.e., titer, IgM, IgG): _____

FOR STATE HEALTH DEPARTMENTS

State Health Department reporting case: _____ State/local ID no.: _____ Date form completed: 07/19/2016

Person completing Report: _____ Email: _____ Phone number: _____

Name of patient's physician: _____ Email: _____ Phone number: _____

CDC 56.60 (E), March 2016, CDC Adobe Acrobat 11.0, S508 Electronic Version, April 2016

Instructions: You must have Internet access and an email address to submit this Form electronically. Upon hitting the 'Submit by Email' button, a PDF is created, attached to an email, which you should then send to the address which appears in the address header; you may also cc: others. Acknowledgment of receipt by CDC is not provided.