NOTE: For use by Local Health Jurisdictions. Boxes shaded in gray not required for State/CDC reporting

CA Version 3-17-03 1500pm

SARS Report Intake Form

Name/affiliation of person filling out form	FIPS Code# **06 -**	___ ___ - ___ ___ ___ ___ AVSS County Code / Four digit County ID# *(First case 0001, etc)*

Date of Report: MM DD	2003	**Time of Report:** : AM PM		

Local Health Department Contact	Name:				
Phone: ( )	Pager: ( )	Other ( )	☐ Phone ☐ Fax	Other ( )	☐ Phone ☐ Fax
If reporter is not from Local Health Department, has HD been notified?	☐ Yes ☐ No ☐ N/A				

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

Patient Information	Last Name:	First Name:			
City of residence:	County of residence:	State of Residence:	ZIP:	Country:	
Phone 1: ( )	☐ Patient ☐ Other	Phone 2: ( )	☐ Patient ☐ Other		
Date of Birth: MM DD YY	Age	☐ Years ☐ Months	Sex	☐ Male ☐ Female	
Race: ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other: _____	Ethnicity: ☐ Hispanic ☐ Non-Hispanic				
Received Influenza Vaccine this year? ☐ Yes ☐ No ☐ Unk					
Occupation	Healthcare worker? ☐ Yes ☐ No	☐ Physician ☐ Nurse ☐ Aide ☐ Staff , non-medical ☐ **Other:** _____			
If Healthcare worker, name of facility_____ Location:_____					
If not a healthcare worker, list occupation:					

Signs and Symptoms	Date of symptom onset	MM DD YY	
Check all signs and symptoms that apply			
☐ Temperature > 38 C (100.4 F) Highest Temperature _____			C F
☐ Cough ☐ Shortness of breath/difficulty breathing ☐ Respiratory Distress Syndrome--ARDS			
☐ Radiographic findings of pneumonia (specify) ☐ Other abnormality:_____	☐ Lobar consolidation ☐ Interstitial infiltrate ☐ Pleural effusion		

□ Other symptoms, ***List:***

□ **WBC** Count: _____Differential:_____ □ **Platelets** Count:_____

□ Other abnormal laboratory results, ***List:***

Clinical status at the time of report:	□ Outpatient □ Emergency Room □ Inpatient □ Died

Was patient hospitalized during course? □ Yes □ No

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

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

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

***If more than one hospitalization,* Date:**	MM	DD	YY	**Date of Discharge**	MM	DD	YY

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

If patient died:	MM	DD	YY	Was pathology consistent with Respiratory Distress Syndrome?	□ Yes □ No □ Unk
Date of death					
Was an autopsy performed	□ Yes	□ No	□ Unk		

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

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 completed at this time:

□ Blood culture(s)	□ Positive □ Negative □ Pending	**Comment:**_____
□ Sputum gram stain	□ Positive □ Negative □ Pending	**Comment:**_____
□ Rapid Influenza test	□ Positive □ Negative □ Pending	**Comment:**_____
□ Respiratory Syncytial Virus	□ Positive □ Negative □ Pending	**Comment:**_____
□ Legionella test	□ Positive □ Negative □ Pending	**Type of Test/Comment:**_____
□ Chlamydia test	□ Positive □ Negative □ Pending	**Type of Test/Comment:**_____
□ Mycoplasma test	□ Positive □ Negative □ Pending	**Type of Test/Comment:**_____
□ BAL Performed	□ Yes □ No	**Comment:**_____

Other diagnostic tests:

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

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

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

Travel History: Did patient travel to any the following destinations within 10 days of symptom onset?

Check all that apply: □ No travel □ Unknown travel history

□ Hong Kong	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
□ Guangdong Province, People's Rep. of China	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
□ Hanoi, Vietnam	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
□ Singapore	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
□ Toronto or Vancouver, Canada	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
□ Other City/State/Country	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
□ Other City/State/Country	**DATES** From:	MM	DD	YY	To:	MM	DD	YY
□ Other City/State/Country	**DATES** From:	MM	DD	YY	To:	MM	DD	YY

Contact history: **In the 10 days before illness onset, did patient have close contact with any person under investigation for SARS?** □ Yes □ No □ Unknown

Close contact = caring for, living with, or having direct contact with respiratory secretions or body fluids of a person with respiratory illness

If yes, contact name: Last: First:	□ Household □ Healthcare worker □ Other work □ Other _____	Contact travel history to area with SARS transmission?	□ Yes □ No □ Unknown
Other contact name: Last: First:	□ Household □ Healthcare worker □ Other work □ Other _____	Contact travel history to area with SARS transmission?	□ Yes □ No □ Unknown
Other contact name: Last: First:	□ Household □ Healthcare worker □ Other work □ Other _____	Contact travel history to area with SARS transmission?	□ Yes □ No □ Unknown

Meets Case Determination: □ Suspect □ Probable □ Under Investigation

Notes:

CDC Case Definition

Persons with onset of illness after February 1, 2003 with:

- fever (>38ºC, 100.4ºF) **AND**
- one or more signs or symptoms of respiratory illness including cough, shortness of breath, difficulty breathing, hypoxia, radiographic findings of pneumonia, or acute respiratory distress syndrome **AND**

One or more of the following:

- travel within 10 days of onset of symptom to an area with documented transmission of SARS (see list below);
- close contact within 10 days of onset of symptoms with a person under investigation or suspected of having SARS.

Note: Suspect cases with either radiographic evidence of pneumonia or respiratory distress syndrome; or evidence of unexplained respiratory distress syndrome by autopsy are designated "probable" cases by the WHO case definition.

* Close contact is defined as having cared for, having lived with or having had direct contact with respiratory secretions and /or body fluids of a patient suspected of having SARS.

List of areas with transmission of SARS (as of 3-17-03): Hong Kong Special Administrative Region and Guangdong province, Peoples' Republic of China; Hanoi, Vietnam; Singapore; and Toronto, Canada.

Recommendations for Suspect Cases (CDC)

a. Save any available clinical specimens (respiratory, blood, and serum) from suspect cases of SARS for additional testing until a specific diagnosis is made
b. Evaluate persons meeting the above description and, if indicated, admit them to the hospital.
c. Advise close contacts and healthcare workers to seek medical care for symptoms of respiratory illness.
d. Follow directions for Infection Control and Treatment as in Important Interim Information and Recommendations for Health Care Providers. http://www.cdc.gov/ncidod/sars/clinician_alert.htm

Completed forms should be faxed to the California Department of Health Services 510-540-2570.