

<b>1. Name/affiliation of person filling out form</b>		STATE ID # (if any)	
Date of Report:	MM	DD	2003
Time of Report:	:	AM	PM
<b>2. State Health Department Contact</b>		Last Name:	First Name:
State:			
Phone: ( )	Pager: ( )	Other ( )	? Phone ( )
			? Fax ( )
If reporter is not from State Health Department, has HD been notified?		? Yes	Notified by EOC?
		? No	? Yes Date:
		? N/A	
<b>3. Reporter or Clinician Contact</b>		Last Name:	First Name:
Hospital or Clinic Name:		City:	
County/Borough:		State:	ZIP:
Phone: ( )	Pager: ( )	Other ( )	? Phone ( )
			? Fax ( )
<b>4. Patient Information</b>		Last Name:	First Name:
City of residence:	County/Boro of residence:	State of Residence:	ZIP: Country:
Phone 1: ( )	? Patient	Phone 2: ( )	? Patient
	? Other		? Other
Date of Birth:	MM	DD	YYYY
Age		? Years	Sex ? Male
		? Months	? Female
Race: ? White ? Black ? Asian/Pacific Islander		Ethnicity: ? Hispanic ? Non-Hispanic	
? American Indian/Alaskan Native ? Other: _____		Nationality: _____	
<b>5. Occupation</b>	Healthcare worker?	? Yes	<i>If yes, specify</i> ? Physician ? Nurse/PA ? Laboratory
		? No	? Other: _____
If <i>not a</i> healthcare worker, list occupation:			
<b>6. Signs and Symptoms</b>		Date of symptom onset:	MM DD YYYY
		Date of fever onset:	MM DD YYYY
<b>Check all signs and symptoms that apply</b>			
? Temperature > 38°C (≥100.5°F)	Highest Temperature _____	? °C	? Cough
		? °F	? Shortness of breath/difficulty breathing
? Hypoxia (Room air O <sub>2</sub> saturation < 94%)		? Respiratory Distress Syndrome—(ARDS)	
? Radiographic findings of pneumonia (specify)			
? Lobar consolidation ? Interstitial infiltrate ? Pleural effusion ? ARDS ? Other:			
_____			

Patient Name : \_\_\_\_\_

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? Other symptoms or relevant findings, List:

Patient Name : \_\_\_\_\_

<b>7. Clinical status at the time of report</b>				? Outpatient ? Emergency Room ? Inpatient ? Died			
Was patient hospitalized for > 24 hours during course? ? Yes ? No ? Unknown							
Was patient admitted to the intensive care unit (ICU)?		? Yes		Is patient currently in ICU?		? Yes	
		? No				? No	
		? Unknown				? Unknown	
Was patient placed on mechanical ventilation?		? Yes		Is patient currently on mechanical ventilator?		? Yes	
		? No				? No	
		? Unknown				? Unknown	
<b>Date of Hospitalization:</b>		MM	DD	YY	<b>Date of Discharge or Death</b>		MM DD YY
<b>Name of Hospital:</b>			<b>City:</b>		<b>State:</b>	<b>Phone number:</b>	
<i>If transferred, Date of transfer:</i>		MM	DD	YY	<b>Date of Discharge or Death from receiving hospital</b>		MM DD YY
<b>Name of Receiving Hospital:</b>			<b>City:</b>		<b>State:</b>	<b>Phone number:</b>	
<i>If patient died: Was an autopsy performed?</i>		? Yes		Was pathology consistent with Respiratory Distress Syndrome?		? Yes	
		? No				? No	
		? Unk				? Unk	
Was pathology consistent with Respiratory Distress Syndrome?							
What was the cause of death based on autopsy? _____ ? Unknown							
<b>8. Diagnostic evaluation:</b>		Has an etiology for patient's illness been determined?				? Yes	
		<i>If yes:</i> list: _____				? No	
<i>Please fill in results of any tests that have been performed at this time:</i>							
.....							
? Blood culture(s) ? Positive ? Negative ? Pending <b>Comment/Result:</b> _____							
? Sputum gram stain ? Positive ? Negative ? Pending <b>Comment/Result:</b> _____							
? Rapid Influenza test ? Positive ? Negative ? Pending <b>Comment/Result:</b> _____							
? Respiratory Syncytial Virus ? Positive ? Negative ? Pending <b>Comment/Result:</b> _____							
? Lowest <b>WBC</b> Count: _____ ? Lowest <b>Platelet</b> Count: _____							
<b>Other pertinent diagnostic tests:</b>							
? Test _____ ? Positive ? Negative ? Pending <b>Comment/Result:</b> _____							
? Test _____ ? Positive ? Negative ? Pending <b>Comment/Result:</b> _____							
? Test _____ ? Positive ? Negative ? Pending <b>Comment/Result:</b> _____							

Patient Name : \_\_\_\_\_

9. Travel History		Did patient travel to any the following destinations within 10 days of symptom onset? ? Yes, <i>specify below</i> ? No ? Unknown travel history							
1. China, mainland	? Yes	If Yes, specify which locations in sections 1a.-1ff. If No or Unk, please skip to section 2.							
	? No								
	? Unk								
a. ? Anhui Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
b. ? Beijing city	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
c. ? Chongqing city	<b>DATES</b> From:	MM	DD	YY	To:		DD	YY	
d. ? Fujian Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
e. ? Gansu Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
f. ? Guizhou Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
g. ? Guangdong Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
h. ? Guangxi Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
i. ? Hainan Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
j. ? Hebei Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
k. ? Heilongjiang Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
l. ? Henan Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
m. ? Hong Kong city	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
n. ? Hubei Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
o. ? Hunan Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
p. ? Jiangsu Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
q. ? Jiangxi Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
r. ? Jilin Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
s. ? Liaoning Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
t. ? Macao city	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
u. ? Inner Mongolia (Nei Mongol) Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	

Patient Name : \_\_\_\_\_

v. ? Ningxia Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
w. ? Qinghai Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
x. ? Shandong Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
y. ? Shanghai city	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
z. ? Shanxi Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
aa. ? Sichuan Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
bb. ? Tianjin city	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
cc. ? Tibet (Xizang) Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
dd. ? Xinjiang Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
ee. ? Yunnan Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
ff. ? Zhejiang Province, PRC	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
2. Hanoi, Vietnam	? Yes	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY
	? No								
	? Unk								
3. Singapore	? Yes	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY
	? No								
	? Unk								
4. ? Other _____ City/State/Country	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
5. ? Other _____ City/State/Country	<b>DATES</b> From:	MM	DD	YY	To:	MM	DD	YY	
6. ? Other _____ City/State/Country	<b>DATES</b> 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?

Patient Name : \_\_\_\_\_

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, <i>specify below</i> ? No ? Don't know			
If yes, please describe what patient did in the hotel?			
Did the patient share any form of transportation with persons who were Metropole Hotel guests? ? Yes, <i>specify below</i> ? No ? Don't know			
If <b>yes</b> , please describe the circumstances:			
<b>10. Flight History</b>		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?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>11. Contact history</b>		In the 10 days prior to onset of symptoms, did the patient have close contact with any person with respiratory illness who traveled to Mainland China and Hong Kong; Hanoi, Vietnam; or Singapore? <i>If yes, give contact information below</i>	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
		In the 10 days prior to onset of symptoms, did the patient care for, live with, or have direct contact with respiratory secretions and/or body fluids of another patient known to be a suspect SARS case? <i>If yes, give contact information below</i>	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
		In the 10 days prior to onset of symptoms, did the patient travel on an airline flight together with another person known to be a suspect SARS case? <i>If yes, give contact information below</i>	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>Contact</b>	Last:	First:	CDC ID#
			<input type="checkbox"/> Household ? Healthcare worker <input type="checkbox"/> Other _____
Did contact travel to area with SARS transmission? ? Yes ? No ? Unknown <i>If yes, where?</i> _____			
<b>Contact</b>	Last:	First:	CDC ID#
			<input type="checkbox"/> Household ? Healthcare worker <input type="checkbox"/> Other _____
Did contact travel to area with SARS transmission? ? Yes ? No ? Unknown <i>If yes, where?</i> _____			
<b>Contact</b>	Last:	First:	CDC ID#
			<input type="checkbox"/> Household ? Healthcare worker <input type="checkbox"/> Other _____
Did contact travel to area with SARS transmission? ? Yes ? No ? Unknown <i>If yes, where?</i> _____			

**Patient Name :** \_\_\_\_\_

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**12. FOR CDC use only : Meets Suspect Case Definition: ? Yes ? No**

**Notes:**

*Please fax completed forms to the California Department of Health Services (510) 540-2570*

**Patient Name :** \_\_\_\_\_