State ID: OR-SARS-_____-2005
(OR-SARS-####-YYYY)

Date: ____/____/_____
mm dd yyyy

SARS Domestic Case Reporting Form

1. Health Department Investigator

Last Name, First Name:		County:
Affiliation:	Phone:	E-mail:

2. Epidemiologic Risk Factors

In the 10 days prior to symptom onset, did the patient have the following?

A. Close contact in the 10 days prior to symptom onset with a laboratory confirmed or probable (epi-link) SARS-CoV case? ☐ Yes ☐ No ☐ Unknown

B. Close contact with a person with a mild to severe clinical illness and an epi-link of possible exposure to SARS-CoV? ☐ Yes ☐ No ☐ Unknown

C. Travel to area with **documented** or **suspected** recent local transmission of SARS cases? *(Mainland China, Taiwan or Hong Kong)* ☐ Yes ☐ No ☐ Unknown

1) *If recent foreign travel*, did the patient receive a **Health Alert** or other SARS educational information on arrival in the United States? ☐ Yes ☐ No ☐ Unknown ☐ N/A

2) *If recent travel*, was the patient **symptomatic** during travel from a SARS affected area or within 24 hours of return to the US or local area? ☐ Yes ☐ No ☐ Unknown ☐ N/A

If YES to A or B, complete form S-1 (for each potential source of infection).
If YES to C, complete form T-1 (for each leg of travel).

3. Patient Information

Last Name, First Name:			Sex: ☐ Male ☐ Female
Address:	City:	State:	Zip:
County:	Home Ph.:	Work Ph.:	Cell/Pager:
Age: ☐ Years ☐ Months	Date of Birth: __ __ / __ __ / __ __ __ __ (mm dd yyyy)		Ethnicity: ☐ Non Hispanic ☐ Hispanic
Nationality/Citizenship:		*Race:* *(Mark one or more)*	☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown
Residency: ☐ US Residency ☐ Non-US Residency			
Primary Language (if not English):			

4. Occupation

Does this person have close contact to patients, patient care areas (e.g., patient room) or patient care items (e.g. linens, patient specimens)? ☐ Yes ☐ No ☐ Unknown

If yes: Specify healthcare worker type: ☐ Physician ☐ Nurse/PA ☐ Lab ☐ Other (specify):_____

Does patient have DIRECT patient care responsibilities? ☐ Yes ☐ No ☐ Unknown

If not a healthcare worker, please list occupation:

5. Clinical Signs and Symptoms

Date of symptom onset: __ __ / __ __ / __ __ __ __
m m d d y y y y

Did the person have a fever (subjective or objective)? ☐ Yes ☐ No ☐ Unknown

If yes:
Date of fever onset: __ __ / __ __ / __ __ __ __
m m d d y y y y

Was temperature >38° C (100.4° F)? ☐ Yes ☐ No ☐ Unknown

Did the patient have any lower respiratory symptoms (e.g., cough, shortness of breath, difficulty breathing)? ☐ Yes ☐ No ☐ Unknown

Was a chest X-ray or CAT scan performed? ☐ Yes ☐ No ☐ Unknown

If yes:

Did the patient have radiographic evidence of pneumonia or respiratory distress syndrome (RDS)? ☐ Yes ☐ No ☐ Unknown

6. Classification of Patient:

☐ Severe respiratory illness with no known epi-link – (RU1)
☐ Mild to moderate respiratory illness and epi-link including possible SARS exposure– (RU2)
☐ Severe respiratory illness and epi-link including possible SARS exposure– (RU3)
☐ Mild to moderate respiratory illness and epi-link including likely SARS exposure– (RU4)
☐ Severe respiratory illness and epi-link including likely SARS exposure– (PS) – Probable SARS
☐ Clinically compatible illness and laboratory confirmation of SARS-CoV– (CS) – Confirmed SARS
☐ Not a Case: negative serology (>28 days post onset)
☐ Not a Case: alternative diagnosis for illness

Date of Initial Classification: __ __ / __ __ / __ __ __ __
m m d d y y y y

Date of Updated Classification: __ __ / __ __ / __ __ __ __
m m d d y y y y

7. Clinical Status

Date of the first health care evaluation for this illness: __ __ / __ __ / __ __ __ __
m m d d y y y y

Was patient hospitalized for > 24 hours during course? ☐ Yes ☐ No ☐ Unknown

If yes: Name of Hospital: _____ City: _____ State: _____

Unit:_____ Floor:_____ Room:_____ Medical Record #:_____

Date of Hospitalization: __ __ / __ __ / __ __ __ __
m m d d y y y y

Date of Discharge: __ __ / __ __ / __ __ __ __
m m d d y y y y

Was patient ever admitted to the intensive care unit (ICU)? ☐ Yes ☐ No ☐ Unknown

Was patient ever placed on mechanical ventilation? ☐ Yes ☐ No ☐ Unknown

Did patient die as a result of this illness? ☐ Yes ☐ No ☐ Unknown

If yes:
Date of Death: __ __ / __ __ / __ __ __ __
m m d d y y y y

Was an autopsy performed? ☐ Yes ☐ No ☐ Unknown

Was pathology consistent with pneumonia or RDS? ☐ Yes ☐ No ☐ Unknown

State ID: OR-SARS-_____-2005
(OR-SARS-####-YYYY)

Date: ___/___/_____
mm dd yyyy

Form T-1

Travel History and Details

List all legs of recent foreign and domestic travel, including destination(s). List all travel by public conveyance (airplane, train bus), with a tour group, in addition to ambulance or other medical transport units. **Include all travel since 24 hours before onset of symptoms.**

Trip or portion (1)

Departure Date: __ __/__ __/__ __ __ __ m m d d y y y y	Departure City:	Arrival Date: __ __/__ __/__ __ __ __ m m d d y y y y	Arrival City:	Transport Type: ☐ Airline ☐ Auto ☐ Train ☐ Tour Group ☐ Cruise ☐ Other ☐ Bus

Transport Company: | Transport No:

Comments:

Trip or portion (2)

Departure Date: __ __/__ __/__ __ __ __ m m d d y y y y	Departure City:	Arrival Date: __ __/__ __/__ __ __ __ m m d d y y y y	Arrival City:	Transport Type: ☐ Airline ☐ Auto ☐ Train ☐ Tour Group ☐ Cruise ☐ Other ☐ Bus

Transport Company: | Transport No:

Comments:

Trip or portion (3)

Departure Date: __ __/__ __/__ __ __ __ m m d d y y y y	Departure City:	Arrival Date: __ __/__ __/__ __ __ __ m m d d y y y y	Arrival City:	Transport Type: ☐ Airline ☐ Auto ☐ Train ☐ Tour Group ☐ Cruise ☐ Other ☐ Bus

Transport Company: | Transport No:

Comments:

Trip or portion (4)

Departure Date: __ __/__ __/__ __ __ __ m m d d y y y y	Departure City:	Arrival Date: __ __/__ __/__ __ __ __ m m d d y y y y	Arrival City:	Transport Type: ☐ Airline ☐ Auto ☐ Train ☐ Tour Group ☐ Cruise ☐ Other ☐ Bus

Transport Company: | Transport No:

Comments:

Trip or portion (5)

Departure Date: __ __/__ __/__ __ __ __ m m d d y y y y	Departure City:	Arrival Date: __ __/__ __/__ __ __ __ m m d d y y y y	Arrival City:	Transport Type: ☐ Airline ☐ Auto ☐ Train ☐ Tour Group ☐ Cruise ☐ Other ☐ Bus

Transport Company: | Transport No:

Comments:

(This page may be duplicated if needed.)

8. Contact Tracing

Use this form to record all close contacts of the case. For daily follow-up of each contact, please complete form C-1.

Name of Contact	Age / Date of Birth	Sex (M/F)	Household? ☑	Priority *	Phone number (if not a household contact)	Address (if not a household contact)	Language*	Date first seen	Immediate Referral? ☑	Symptomatic? ☑	Became case? ☑	Follow-up complete? ☑	Notes

(This page may be duplicated if needed.)

***Priority Codes:**
1 = <3 feet
2 = >3 feet

***Language Codes:**
E = English **V = Vietnamese** **R = Russian**
S = Spanish **C = Chinese** **O = Other (if other, specify in notes)**

State ID: OR-SARS-_____-2005
(OR-SARS-####-YYYY)

Date: ____/____/_____
mm dd yyyy

Form C-1

Contact Management

Last Name, First Name:		Date of Most Recent Exposure: __ __ / __ __ / __ __ __ __
Sex: ☐ Male ☐ Female	Age: ☐ Years ☐ Months	Date of Birth: __ __ / __ __ / __ __ __ __ (m m d d y y y y)
Race: (Check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black ☐ White ☐ Unknown		Ethnicity: ☐ Non-Hispanic ☐ Hispanic
Relationship to case:	Comments:	
Same household as case? ☐ Yes ☐ No ☐ Unknown	**If different household – complete section below:**	

Street Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell or Pager:	

Daily Management: Day 1	**☐ Face-to-Face Interview AM PM (circle AM or PM for time conducted)**	
Today's date: __ __ / __ __ / __ __ __ __	Number of days post exposure:	☐ Quarantine
AM Temperature:	PM Temperature:	
Symptoms: ☐ Difficulty breathing ☐ Cough ☐ Fever ☐ Bodyache ☐ Headache ☐ Other ☐ None		
Daily Notes:		
Daily Management: Day 2	**☐ Face-to-Face Interview AM PM ☐ Telephone Interview AM PM**	
Today's date: __ __ / __ __ / __ __ __ __	Number of days post exposure:	☐ Quarantine
AM Temperature:	PM Temperature:	
Symptoms: ☐ Difficulty breathing ☐ Cough ☐ Fever ☐ Bodyache ☐ Headache ☐ Other ☐ None		
Daily Notes:		
Daily Management: Day 3	**☐ Face-to-Face Interview AM PM ☐ Telephone Interview AM PM**	
Today's date: __ __ / __ __ / __ __ __ __	Number of days post exposure:	☐ Quarantine
AM Temperature:	PM Temperature:	
Symptoms: ☐ Difficulty breathing ☐ Cough ☐ Fever ☐ Bodyache ☐ Headache ☐ Other ☐ None		
Daily Notes:		
Daily Management: Day 4	**☐ Face-to-Face Interview AM PM ☐ Telephone Interview AM PM**	
Today's date: __ __ / __ __ / __ __ __ __	Number of days post exposure:	☐ Quarantine
AM Temperature:	PM Temperature:	
Symptoms: ☐ Difficulty breathing ☐ Cough ☐ Fever ☐ Bodyache ☐ Headache ☐ Other ☐ None		
Daily Notes:		
Daily Management: Day 5	**☐ Face-to-Face Interview AM PM ☐ Telephone Interview AM PM**	
Today's date: __ __ / __ __ / __ __ __ __	Number of days post exposure:	☐ Quarantine
AM Temperature:	PM Temperature:	
Symptoms: ☐ Difficulty breathing ☐ Cough ☐ Fever ☐ Bodyache ☐ Headache ☐ Other ☐ None		
Daily Notes:		

(This page may be duplicated if needed.)

State ID: OR-SARS-_____-2005
(OR-SARS-####-YYYY)

Date: ___/___/_____
mm dd yyyy

Contact Last Name, First Name:_____ Date of Most Recent Exposure: __ __ / __ __ / __ __ __ __

Daily Management: Day 6	☐ **Face-to-Face Interview AM PM**	☐ **Telephone Interview AM PM**
Today's date: __ __ / __ __ / __ __ __ __	Number of days post exposure:	☐ Quarantine
AM Temperature:	PM Temperature:	
Symptoms: ☐ Difficulty breathing ☐ Cough ☐ Fever ☐ Bodyache ☐ Headache ☐ Other ☐ None		
Daily Notes:		

Daily Management: Day 7	☐ **Face-to-Face Interview AM PM**	☐ **Telephone Interview AM PM**
Today's date: __ __ / __ __ / __ __ __ __	Number of days post exposure:	☐ Quarantine
AM Temperature:	PM Temperature:	
Symptoms: ☐ Difficulty breathing ☐ Cough ☐ Fever ☐ Bodyache ☐ Headache ☐ Other ☐ None		
Daily Notes:		

Daily Management: Day 8	☐ **Face-to-Face Interview AM PM**	☐ **Telephone Interview AM PM**
Today's date: __ __ / __ __ / __ __ __ __	Number of days post exposure:	☐ Quarantine
AM Temperature:	PM Temperature:	
Symptoms: ☐ Difficulty breathing ☐ Cough ☐ Fever ☐ Bodyache ☐ Headache ☐ Other ☐ None		
Daily Notes:		

Daily Management: Day 9	☐ **Face-to-Face Interview AM PM**	☐ **Telephone Interview AM PM**
Today's date: __ __ / __ __ / __ __ __ __	Number of days post exposure:	☐ Quarantine
AM Temperature:	PM Temperature:	
Symptoms: ☐ Difficulty breathing ☐ Cough ☐ Fever ☐ Bodyache ☐ Headache ☐ Other ☐ None		
Daily Notes:		

Daily Management: Day 10	☐ **Face-to-Face Interview AM PM**	☐ **Telephone Interview AM PM**
Today's date: __ __ / __ __ / __ __ __ __	Number of days post exposure:	☐ Quarantine
AM Temperature:	PM Temperature:	
Symptoms: ☐ Difficulty breathing ☐ Cough ☐ Fever ☐ Bodyache ☐ Headache ☐ Other ☐ None		
Daily Notes:		

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Laboratory Evaluation

9. Specimen Collection Details		
Accession #:		
Date collected:	Date sent to CDC:	
Specimen Type:	If tissue, description:	
Consent to EIA?	Consent to PCR?	
Test:	Testing Source:	Test Result:
Was an alternative Pathogen detected?	If yes, which one? Other:	
Comments:		

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*** CALL 503-731-4024 FOR GUIDANCE ON HOW TO SUBMIT A VIROLOGY REQUEST FOR SARS SPECIMENS AT THE OREGON STATE PUBLIC HEALTH LABORATORY.**

Notes:

PLEASE FAX FORMS TO: 503-731-4798
SARS SURVEILLANCE OFFICER
OREGON DHS/HEALTH SERVICES
ACUTE & COMMUNICABLE DISEASE

State ID: OR-SARS-_____-2005
(OR-SARS-####-YYYY)

Date: ____/____/_____
m m d d y y y y

Form S-1

Potential Sources of Infection

Complete for each contact who was a potential source of infection for this case

Source (1)

Last Name, First Name:

Classification of Contact:	**Nature of contact:**	Contact Start: __ __ / __ __ / __ __ __ __
□ Mild to moderate illness	□ Same household	m m d d y y y y
□ Severe illness	□ Coworker	
□ Probable SARS CoV case	□ Healthcare environment	Contact End: __ __ / __ __ / __ __ __ __
□ Confirmed SARS CoV case	□ Other _____	m m d d y y y y

Did this person recently travel to an area with SARS transmission? *(Mainland China, Taiwan or Hong Kong) If Yes, where?* □ Yes □ No □ Unknown

Travel Start Date: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Travel End Date: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Comments:

Source (2)

Last Name, First Name:

Classification of Contact:	**Nature of contact:**	Contact Start: __ __ / __ __ / __ __ __ __
□ Mild to moderate illness	□ Same household	m m d d y y y y
□ Severe illness	□ Coworker	
□ Probable SARS CoV case	□ Healthcare environment	Contact End: __ __ / __ __ / __ __ __ __
□ Confirmed SARS CoV case	□ Other _____	m m d d y y y y

Did this person recently travel to an area with SARS transmission? *(Mainland China, Taiwan or Hong Kong) If Yes, where?* □ Yes □ No □ Unknown

Travel Start Date: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Travel End Date: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Comments:

Source (3)

Last Name, First Name:

Classification of Contact:	**Nature of contact:**	Contact Start: __ __ / __ __ / __ __ __ __
□ Mild to moderate illness	□ Same household	m m d d y y y y
□ Severe illness	□ Coworker	
□ Probable SARS CoV case	□ Healthcare environment	Contact End: __ __ / __ __ / __ __ __ __
□ Confirmed SARS CoV case	□ Other _____	m m d d y y y y

Did this person recently travel to an area with SARS transmission? *(Mainland China, Taiwan or Hong Kong) If Yes, where?* □ Yes □ No □ Unknown

Travel Start Date: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Travel End Date: __ __ / __ __ / __ __ __ __ (m m d d y y y y)

Comments:

(This page may be duplicated if needed.)