

**North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

**SARS (CORONAVIRUS INFECTION)
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 71**

**ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease.
Enter all information from this form into the NC EDSS question packages.**

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

<p>CLINICAL FINDINGS</p> <p>Is/was patient symptomatic for this disease? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>If yes, symptom onset date (mm/dd/yyyy): / /</p> <p>Fever <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p><input type="checkbox"/> Yes, subjective <input type="checkbox"/> No <input type="checkbox"/> Yes, measured <input type="checkbox"/> Unknown</p> <p>Highest measured temperature _____</p> <p>Fever onset date (mm/dd/yyyy): / /</p> <p>Sweats (diaphoresis) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Cough <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Onset date (mm/dd/yyyy): / /</p> <p>Productive <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Describe (check all that apply)</p> <p><input type="checkbox"/> Clear <input type="checkbox"/> Purulent <input type="checkbox"/> Bloody (hemoptysis)</p> <p>Shortness of breath/difficulty breathing/respiratory distress <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Acute Respiratory Distress Syndrome (ARDS) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Pathology consistent with respiratory distress syndrome <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Did the patient have a chest x-ray? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Describe (check all that apply)</p> <p><input type="checkbox"/> Normal <input type="checkbox"/> Infiltrate <input type="checkbox"/> Diffuse infiltrates / findings suggestive of ARDS <input type="checkbox"/> Pleural effusion <input type="checkbox"/> Other</p> <p>Pneumonia <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Confirmed by x-ray or CT <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Describe (select all that apply)</p> <p><input type="checkbox"/> Bloody <input type="checkbox"/> Non-bloody <input type="checkbox"/> Watery <input type="checkbox"/> Other</p>	<p>REASON FOR TESTING</p> <p>Why was the patient tested for this condition?</p> <p><input type="checkbox"/> Symptomatic of disease <input type="checkbox"/> Screening of asymptomatic person with reported risk factor(s) <input type="checkbox"/> Exposed to organism causing this disease (asymptomatic) <input type="checkbox"/> Household / close contact to a person reported with this disease <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Unknown</p>	<p>TREATMENT</p> <p>Did the patient receive an antiviral for this illness? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Specify antiviral name: _____</p> <p>Date antiviral treatment began (mm/dd/yyyy): / /</p> <p>Time treatment began: <input type="checkbox"/> AM <input type="checkbox"/> PM</p> <p>Number of days taken: <input type="checkbox"/> Unknown</p> <p>Did the patient require supplemental oxygen? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Date started (mm/dd/yyyy): / /</p> <p>Did the patient require mechanical ventilation? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Date started (mm/dd/yyyy): / /</p> <p>Number of days on mechanical ventilation: _____</p>
<p>PREDISPOSING CONDITIONS</p> <p>Any immunosuppressive conditions? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Specify _____</p>	<p>HOSPITALIZATION INFORMATION</p> <p>Was patient hospitalized for this illness >24 hours? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Hospital name: _____</p> <p>City, State: _____</p> <p>Hospital contact name: _____</p> <p>Telephone: (____) ____ - _____</p> <p>Admit date (mm/dd/yyyy): / /</p> <p>Discharge date (mm/dd/yyyy): / /</p> <p>ICU admission? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p>	

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? Y N

Check all that apply:

Work Sexual behavior

Child care Blood and body fluid

School Other, specify _____

Date control measures issued: ____/____/____

Date control measures ended: ____/____/____

Was patient compliant with control measures? Y N

Local health director or designee implement additional control measures? Y N

If yes, specify: _____

Were written isolation orders issued?.. Y N

If yes, where was the patient isolated? _____

Date isolation started: ____/____/____

Date isolation ended: ____/____/____

Was the patient compliant with isolation? Y N

Were written quarantine orders issued? Y N

If yes, where was the patient quarantined? _____

Date quarantine started: ____/____/____

Date quarantine ended: ____/____/____

Was the patient compliant with quarantine?..... Y N

TRAVEL & IMMIGRATION

The patient is:

Resident of NC

Resident of another state or US territory

Foreign Visitor

Refugee

Recent Immigrant

Foreign Adoptee

None of the above

Did patient have a travel history during the 10 days prior to onset?..... Y N U

List travel dates and destinations:

From ____/____/____ to ____/____/____

Mode(s) of transportation (check all that apply)

Airplane Train / subway

Ship / boat / ferry On foot

Automobile / motorcycle Bus/taxi/shuttle

Other, specify: _____

Was patient pregnant while traveling? Y N U

If yes, was travel during the first trimester of pregnancy? Y N U

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? Y N U

Name: _____

Did patient have contact with a person with travel history during the period of interest?..... Y N U

Contact's name: _____

Travel dates:

From: ____/____/____ until ____/____/____

To city: _____

To state: _____

To country: _____

BEHAVIORAL RISK & CONGREGATE LIVING

During the 10 days prior to onset of symptoms did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? Y N U

Name of facility: _____

Dates of contact: _____

During the 10 days prior to onset, did the patient attend social gatherings or crowded settings? Y N U

If yes, specify: _____

In what setting was the patient most likely exposed?

Restaurant

Home

Work

Child Care

School

University / College

Camp

Doctor's office / Outpatient clinic

Hospital In-patient

Hospital Emergency Department

Laboratory

Long-term care facility / Rest Home

Military

Prison / Jail / Detention Center

Place of Worship

Outdoors, including woods or wilderness

Athletics

Farm

Pool or spa

Pond, lake, river or other body of water

Hotel / motel

Social gathering, other than listed above

Travel conveyance (airplane, ship, etc.)

International

Community

Other (specify) _____

Unknown

Does the patient have any other risk for this disease? Y N U

Specify: _____

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? Y N U

Died?..... Y N U

Died from this illness? Y N U

Date of death (mm/dd/yyyy): ____/____/____

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? Y N U

Patient a child care worker or volunteer in child care? Y N U

Patient a parent or primary caregiver of a child in child care? Y N U

Is patient a student?..... Y N U

Type of school: _____

Is patient a school WORKER / VOLUNTEER in NC school setting? Y N U

Give details: _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 10 days prior to onset of symptoms, did the patient have any of the following exposures:

Emergency Department (not hospitalized) Y N U
 Facility name _____
 City _____
 State _____
 Country _____

Hospitalized
 Visit / admit date (mm/dd/yyyy): ___/___/___
 Facility name _____
 Has patient been discharged? Y N U
 Discharge date (mm/dd/yyyy): ___/___/___
 Was facility notified regarding ill patient?
 Yes No Unknown Not applicable
 Name of person notified _____
 Date notified (mm/dd/yyyy): ___/___/___

Long term care facility - resident (e.g. nursing home, rest home, rehab)
 Visit/admit date (mm/dd/yyyy): ___/___/___
 Facility name _____
 City _____ State _____
 Country _____
 Has patient been discharged? Y N U
 Discharge date (mm/dd/yyyy): ___/___/___
 Was facility notified regarding ill patient?
 Yes No Unknown Not applicable
 Name of person notified _____
 Date notified (mm/dd/yyyy): ___/___/___

Outpatient facility - patient (e.g. urgent care, clinic, physician office)
 Visit / admit date (mm/dd/yyyy): ___/___/___
 Facility name _____
 Has patient been discharged? Y N U
 Discharge date (mm/dd/yyyy): ___/___/___
 Was facility notified regarding ill patient?
 Yes No Unknown Not applicable
 Name of person notified _____
 Date notified (mm/dd/yyyy): ___/___/___

Visitor to health care setting
 Facility name _____
 City _____ State _____
 Country _____

Worked or volunteered in health care or clinical setting
 Facility name _____
 City _____ State _____
 Country _____

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U
 If yes, specify: _____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U
 Date of interview (mm/dd/yyyy): ___/___/___
Were interviews conducted with others? Y N U
 Who was interviewed? _____

Were health care providers consulted? Y N U
 Who was consulted? _____

Medical records reviewed (including telephone review with provider/office staff)? Y N U
 Specify reason if medical records were not reviewed: _____

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?
 Specify location:
 In NC
 City _____
 County _____
 Outside NC, but within US
 City _____
 State _____
 County _____
 Outside US
 City _____
 Country _____
 Unknown

Is the patient part of an outbreak of this disease? Y N

Notes:

SARS (coronavirus infection)

2003 CDC Case Definition

Refer to the Centers for Disease Control and Prevention (CDC) SARS web site for the surveillance case definition for SARS-CoV disease and other related information maintained by the National Center for Infectious Diseases (URL: www.cdc.gov/ncidod/sars/reporting.htm).

Note

Only cases of SARS-CoV disease are considered nationally notifiable. The SARS surveillance case definition also includes a non-specific case definition for “SARS reports under investigation.” While States are encouraged to report both SARS reports under investigation and SARS-CoV disease, only SARS-CoV disease has been added to the national notifiable diseases list.

See also

SARS reports under investigation at URL: www.cdc.gov/ncidod/sars/reporting.htm.