



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

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

<b>Medical provider completing clinical component of surveillance form:</b> Name/Title: _____ Telephone: (____) ____ - ____ Fax: (____) ____ - ____ Date completed ____/____/____	<b>LHD CD nurse/designee completing form for submission to DPH:</b> Name/Title (print): _____ Telephone: (____) ____ - ____ Date completed ____/____/____ LHD CD nurse/designee signature _____
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**LOCAL HEALTH DEPARTMENT USE ONLY**

**Check one:**  
 **Case definition is met.**  
 (Complete Part 1 and Part 2 and submit to state)  
 **Case definition is not met.**  
 (Complete Part 2 only and submit to state)

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**GENERAL DIAGNOSTIC INFORMATION**

Is/was patient symptomatic?.....  Y  N  U  
 Date of illness onset (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of diagnosis (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Patient's health care provider for this illness  
 \_\_\_\_\_  
 Name of provider's practice or facility  
 \_\_\_\_\_  
 Telephone number for health care provider  
 (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**PREDISPOSING CONDITIONS**

Any immunosuppressive conditions?  Y  N  U  
 Specify \_\_\_\_\_  
 \_\_\_\_\_

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**REASON FOR TESTING**

Why was the patient tested for this condition?  
 Symptomatic of disease  
 Screening of asymptomatic person with reported risk factor(s)  
 Exposed to organism causing this disease (asymptomatic)  
 Household / close contact to a person reported with this disease  
 Other, specify \_\_\_\_\_  
 Unknown

**TREATMENT**

Did the patient receive an antiviral for this illness? .....  Y  N  U  
 Specify antiviral name: \_\_\_\_\_  
 Date antiviral treatment began (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Time treatment began: \_\_\_\_\_  AM  PM  
 Number of days taken: \_\_\_\_\_  Unknown

Did the patient require supplemental oxygen? .....  Y  N  U  
 Date started (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Did the patient require mechanical ventilation? .....  Y  N  U  
 Date started (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Number of days on mechanical ventilation: \_\_\_\_\_

**CLINICAL FINDINGS**

Fever .....  Y  N  U  
 Yes, subjective  No  
 Yes, measured  Unknown  
 Highest measured temperature \_\_\_\_\_  
 Fever onset date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Sweats (diaphoresis).....  Y  N  U  
 Cough .....  Y  N  U  
 Onset date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Productive .....  Y  N  U  
 Describe (check all that apply)  
 Clear  
 Purulent  
 Bloody (hemoptysis)

Shortness of breath/difficulty breathing/ respiratory distress.....  Y  N  U  
**Acute Respiratory Distress Syndrome (ARDS)**.....  Y  N  U  
**Pathology consistent with respiratory distress syndrome** .....  Y  N  U  
**Did the patient have a chest x-ray?**  Y  N  U  
 Describe (check all that apply)  
 Normal  
 Infiltrate  
 Diffuse infiltrates / findings suggestive of ARDS  
 Pleural effusion  
 Other

**Pneumonia** .....  Y  N  U  
 Confirmed by x-ray or CT.....  Y  N  U

**Diarrhea** .....  Y  N  U  
 Describe (select all that apply)  
 Bloody  
 Non-bloody  
 Watery  
 Other

**Maximum number of stools in a 24-hour period:** \_\_\_\_\_  
**Other symptoms, signs, clinical findings, or complications consistent with this illness**.....  Y  N  U  
 Please specify:

**HOSPITALIZATION INFORMATION**

**Was patient hospitalized for this illness >24 hours?** .....  Y  N  U  
 Hospital name: \_\_\_\_\_  
 City, State: \_\_\_\_\_  
 Hospital contact name: \_\_\_\_\_  
 Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 Admit date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Discharge date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 ICU admission?.....  Y  N  U

Patient's First Name	Middle	Last	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
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**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 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, has the patient attended 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: \_\_\_\_\_

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						SSN / /

**HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS**

During the 10 days prior to onset, 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 suspected of being part of a common source outbreak? .....  Y  N  U

Notes: \_\_\_\_\_

**DIAGNOSTIC TESTING**

Give details below.

Collection Date	Result Date	Type of Test	Specimen Source	Results (include serogroup/type)	Reference Range	Lab Name/City/State
	/ /					
	/ /					
	/ /					

**2003 CDC/CSTE CASE DEFINITION**  
**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: <http://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.