

HANTAVIRUS PULMONARY SYNDROME INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name: _____ First Name: _____ Middle Name: _____

DOB: ___/___/_____ Age: _____ years months Current Sex: Female Male Unknown

Is the patient deceased? No Unknown Yes Date of Death: ___/___/_____

Marital Status: Married Single, never married Widowed Annulled
 Domestic partner Interlocutory Legally separated Divorced
 Polygamous Refused to answer Unknown

SSN: _____-_____-_____

Street Address 1: _____ Street Address 2: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: (____)-____-____ Cell Phone: (____)-____-____ Work Phone: (____)-____-____ Ext. _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White Unknown

INVESTIGATION SUMMARY

Investigation Start Date: ___/___/_____ Investigation Status: Open Closed Investigator: _____

REPORTING SOURCE

Date of Report: ___/___/_____ Reporting Source: _____

Reporting Source Name: _____

CLINICAL

Physician's Name: _____ Phone Number: (____)-____-____ Ext. _____

Was patient hospitalized for this illness? No Unknown Yes If yes: Hospital Name: _____

Admission Date: ___/___/_____ Discharge Date: ___/___/_____ Duration of Stay _____ day(s)

Diagnosis Date: ___/___/_____ Illness Onset Date: ___/___/_____ Illness End Date: ___/___/_____

Age at Onset: _____ days hours minutes months unknown weeks years

Is the patient pregnant? No Unknown Yes

Does the patient have pelvic inflammatory disease? No Unknown Yes

Did the patient die from this illness? No Unknown Yes Date of Death: ___/___/_____

EPIDEMIOLOGIC

Is this patient associated with a day care facility? No Unknown Yes

Is this patient a food handler? No Unknown Yes

Is this case part of an outbreak? No Unknown Yes If yes, outbreak name: _____

Where was the disease acquired? Indigenous within jurisdiction Out of Country Out of jurisdiction, from another jurisdiction
 Out of State Unknown

If selection is out of country, state, or jurisdiction, where was the disease acquired?

Country: _____ State: _____ City: _____ County: _____

Transmission Mode: Airborne Bloodborne Dermal Foodborne Indeterminate Mechanical Nosocomial Sexually Transmitted
 Transplacental transmission Vectorborne Waterborne Zoonotic Unknown

Detection Method: Patient self-referral Prenatal testing Prison entry screening Provider reported Routine physical Other

Confirmation Method: Active Surveillance Case/Outbreak Investigation Clinical diagnosis (non-laboratory confirmed)
 Epidemiologically linked Laboratory confirmed Laboratory report Local/State specified Medical record review
 No information given Occupational disease surveillance Provider certified Other

Confirmation Date: ___ / ___ / _____

Case Status: Confirmed Not a Case Unknown MMWR Week: _____ MMWR Year: _____

ADMINISTRATIVE

General Comments:

CLINICAL CRITERIA

Fever (>101.0 F): No Unknown Yes
Chills: No Unknown Yes
Myalgia : No Unknown Yes
Headache: No Unknown Yes
Dizziness: No Unknown Yes
Cough: No Unknown Yes
Shortness of breath: No Unknown Yes
Nausea: No Unknown Yes
Vomiting: No Unknown Yes
Diarrhea: No Unknown Yes
Abdominal cramps: No Unknown Yes
Bilateral diffuse interstitial edema: No Unknown Yes
Acute Respiratory Distress Syndrome (ARDS): No Unknown Yes
Noncardiogenic pulmonary edema: No Unknown Yes

BLOOD TESTING CRITERIA (need 3/5)

Thrombocytopenia (<150,000 platelets): No Unknown Yes
Elevated hematocrit: No Unknown Yes
Elevated creatinine: No Unknown Yes
Left shift (high immature leukocytes): No Unknown Yes
Absence of toxic granules in neutrophils: No Unknown Yes
Atypical lymphocytes: No Unknown Yes

LABORATORY FINDINGS

* Lab results from commercial labs should be reflexed to a reference lab like CDC to classify a case

Hantavirus-specific IgM: No Unknown Yes

Rising titers of hantavirus-specific IgG: No Unknown Yes

Hantavirus-specific RNA: No Unknown Yes

Hantavirus-specific antigen by IHC: No Unknown Yes

PRE-HOSPITAL TREATMENT

Did patient seek care before admission? No Unknown Yes

If yes, date: ___/___/_____

If yes, outcome of previous admission:

HOSPITAL COURSE

Supplemental oxygen required? No Unknown Yes

Was patient on ECMO? No Unknown Yes

Was patient intubated? No Unknown Yes

CXR with unexplained bilateral interstitial infiltrates or suggestive of ARDS? No Unknown Yes

EXPOSURE INFORMATION

History of rodent exposure 8 weeks prior to illness? No Unknown Yes

If yes, type of rodent exposure: _____

Place of contact (town, county, state): _____

Did exposure occur while cleaning? No Unknown Yes

Did exposure occur by working? No Unknown Yes

Did exposure occur during recreational activity (camping, hiking)? No Unknown Yes

If applicable, please list other exposures:

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

- | | | |
|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> CSF leak | <input type="checkbox"/> Hodgkin's disease | <input type="checkbox"/> IVDU |
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Asthma | <input type="checkbox"/> Atherosclerotic cardiovascular disease (ASCVD)/CAD |
| <input type="checkbox"/> Burns | <input type="checkbox"/> Cerebral vascular accident (CVA) stroke | <input type="checkbox"/> Chronic GI illness/diarrhea |
| <input type="checkbox"/> Cirrhosis/liver failure | <input type="checkbox"/> Cochlear implant | <input type="checkbox"/> Current smoker |
| <input type="checkbox"/> Deaf/profound hearing loss | <input type="checkbox"/> Diabetes mellitus (insulin): <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> Yes | <input type="checkbox"/> Emphysema/COPD |
| <input type="checkbox"/> Gastric surgery (type): _____ | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Hematologic disease (type): _____ |
| <input type="checkbox"/> Immunodeficiency (type): _____ | <input type="checkbox"/> Immunoglobulin deficiency | <input type="checkbox"/> Immunosuppressive therapy (steroids, chemotherapy) |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Multiple myeloma | <input type="checkbox"/> Nephrotic Syndrome |
| <input type="checkbox"/> None | <input type="checkbox"/> Organ transplant (organ): _____ | <input type="checkbox"/> Other liver disease (type): _____ |
| <input type="checkbox"/> Other malignancy (type): _____ | <input type="checkbox"/> Other prior illness (type): _____ | <input type="checkbox"/> Other renal disease (type): _____ |
| <input type="checkbox"/> Peptic ulcer | <input type="checkbox"/> Renal failure/dialysis | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Splenectomy/asplenia | <input type="checkbox"/> Systemic lupus erythematosus (SLE) | <input type="checkbox"/> Unknown |

RELATED CASES

Does the patient know of any similarly ill persons? No Unknown Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further: No Unknown Yes

Are the other cases related to this one? No, sporadic Unknown Yes, household Yes, not household Yes, outbreak

Note: Please enter Case ID of epi-linked case(s) in the General Comments section of the ALNBS Investigation.

OUTCOME

Survived? No Unknown Yes

Still ill? No Unknown Yes

Unknown? No Unknown Yes

Died? No Unknown Yes

If yes, date of death: ___ / ___ / _____

Autopsy performed? No Unknown Yes

If applicable, autopsy findings:
