

# SARS-CoV<sup>†</sup> INVESTIGATION FORM

**STOP: PRIOR TO CREATING THIS INVESTIGATION, YOU MUST NOTIFY & CONSULT WITH CENTRAL OFFICE  
(800) 338-8374 (24-HOUR COVERAGE)**

<sup>†</sup> SEVERE ACUTE RESPIRATORY SYNDROME-ASSOCIATED CORONAVIRUS (SARS-CoV)

## 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: \_\_\_/\_\_\_/\_\_\_\_\_

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: \_\_\_\_\_

## 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

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: \_\_\_\_\_

Case Status:  Confirmed  Not a Case  Probable  Suspect  Unknown MMWR Week: \_\_\_\_\_ MMWR Year: \_\_\_\_\_

## ADMINISTRATIVE

General Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PHA4 SUPERVISOR REVIEW

Date Due: \_\_\_/\_\_\_/\_\_\_\_\_ Investigation ready for supervisor review:  Reviewed (Complete)  Reviewed (Incomplete)

Date investigation ready for supervisor review: \_\_\_/\_\_\_/\_\_\_\_\_  Reviewed (Not a case)  Yes

Review comments (completed by supervisor): \_\_\_\_\_



**Supplement B: SARS Surveillance**

(continued from previous page)

Was patient ever placed on mechanical ventilation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Did patient die as a result of his/her illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<i>If yes:</i>	
Date of Death: ___ / ___ / _____	
<small>m m      d d      y y y y</small>	
Was an autopsy performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Was pathology consistent with pneumonia or RDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

**Epidemiologic Risk Factors**

7. Occupation	
Is the individual a healthcare worker?*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<i>* A person who has close contact to patients, patient care areas (e.g., patient room) or patient care items (e.g. linens, patient specimens).</i>	
<i>If yes:</i>	<input type="checkbox"/> Physician <input type="checkbox"/> Nurse/PA <input type="checkbox"/> Lab <input type="checkbox"/> Other Specify: _____
Specify healthcare worker type:	
Does patient have DIRECT patient care responsibilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If not a healthcare worker, please list occupation: _____	

8. Contact and Travel	
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 confirmed SARS-CoV case or a probable SARS-CoV case? *	<input type="checkbox"/> Yes If yes, go to section 9, then return <input type="checkbox"/> No <input type="checkbox"/> Unknown
<i>* SEE APPENDIX B1 FOR CLASSIFICATION DEFINITIONS</i>	
B. Close contact with a person considered an RUI-2 or RUI-3? *	<input type="checkbox"/> Yes If yes, go to section 9, then return <input type="checkbox"/> No <input type="checkbox"/> Unknown
<i>* SEE APPENDIX B1 FOR CLASSIFICATION DEFINITIONS</i>	

**Supplement B: SARS Surveillance**

(continued from previous page)

Was patient ever placed on mechanical ventilation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Did patient die as a result of his/her illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<i>If yes:</i>	
Date of Death: ___ / ___ / _____	
<small>m m      d d      y y y y</small>	
Was an autopsy performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Was pathology consistent with pneumonia or RDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

**Epidemiologic Risk Factors**

7. Occupation	
Is the individual a healthcare worker?*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<i>* A person who has close contact to patients, patient care areas (e.g., patient room) or patient care items (e.g. linens, patient specimens).</i>	
<i>If yes:</i>	<input type="checkbox"/> Physician <input type="checkbox"/> Nurse/PA <input type="checkbox"/> Lab <input type="checkbox"/> Other Specify: _____
Specify healthcare worker type:	
Does patient have DIRECT patient care responsibilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If not a healthcare worker, please list occupation: _____	

8. Contact and Travel	
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 confirmed SARS-CoV case or a probable SARS-CoV case? *	<input type="checkbox"/> Yes If yes, go to section 9, then return <input type="checkbox"/> No <input type="checkbox"/> Unknown
<i>* SEE APPENDIX B1 FOR CLASSIFICATION DEFINITIONS</i>	
B. Close contact with a person considered an RUI-2 or RUI-3? *	<input type="checkbox"/> Yes If yes, go to section 9, then return <input type="checkbox"/> No <input type="checkbox"/> Unknown
<i>* SEE APPENDIX B1 FOR CLASSIFICATION DEFINITIONS</i>	

**Supplement B: SARS Surveillance**

(continued from previous page)

<p>C. Travel to <b>foreign</b> or <b>domestic</b> area with documented or suspected recent local transmission of SARS cases? <i>(See list of areas at end of document)</i></p>	<input type="checkbox"/> Yes Enter Destination Below <input type="checkbox"/> No <input type="checkbox"/> Unknown
<p><i>If yes to C, list travel destination(s) (See list of areas at end of document)</i></p>	
<p>Destination: _____</p>	
Date of Arrival: __ __ / __ __ / __ __ __ __ m m d d y y y y	Date of Departure: __ __ / __ __ / __ __ __ __ m m d d y y y y
<p>Destination: _____</p>	
Date of Arrival: __ __ / __ __ / __ __ __ __ m m d d y y y y	Date of Departure: __ __ / __ __ / __ __ __ __ m m d d y y y y
<p>Destination: _____</p>	
Date of Arrival: __ __ / __ __ / __ __ __ __ m m d d y y y y	Date of Departure: __ __ / __ __ / __ __ __ __ m m d d y y y y
<p>Destination: _____</p>	
Date of Arrival: __ __ / __ __ / __ __ __ __ m m d d y y y y	Date of Departure: __ __ / __ __ / __ __ __ __ m m d d y y y y

**Contact History**

<p><b>9. Information on Ill Contacts</b>  <i>Add Contact information for ill contacts identified by question 8A or 8B above. These ill contacts should have been identified previously and have been given either a CDC or STATE ID. If an ID has not been given, enter contact name, but update when ID number is available.</i></p>
<p><b>Contact Information (1)</b></p>
<p>Contact CDC ID: _____ OR Contact STATE ID: _____</p>
<p>OR <i>(only if ID unavailable)</i> Name of Contact (first, middle initial, last): _____</p>

**Supplement B: SARS Surveillance**

(continued from previous page)

Classification of Contact (SEE APPENDIX B1): <input type="checkbox"/> RUI-2 <input type="checkbox"/> RUI-3 <input type="checkbox"/> Probable SARS CoV case <input type="checkbox"/> Confirmed SARS CoV case	Nature of contact: <input type="checkbox"/> Same household <input type="checkbox"/> Coworker <input type="checkbox"/> Healthcare environment <input type="checkbox"/> Other _____	Contact Start: ____ / ____ / ____ m m / d d / y y y y Contact End: ____ / ____ / ____ m m / d d / y y y y
Did the ill <b>contact</b> recently travel to an area with SARS transmission? <i>(see list of areas at end of document)</i>		
If Yes, where? _____		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>Contact Information (2)</b>		
Contact CDC ID: _____ OR Contact STATE ID: _____		
OR <i>(only if ID unavailable)</i> Name of Contact (first, middle initial, last): _____		
Classification of Contact (SEE APPENDIX B1): <input type="checkbox"/> RUI-2 <input type="checkbox"/> RUI-3 <input type="checkbox"/> Probable SARS CoV case <input type="checkbox"/> Confirmed SARS CoV case	Nature of contact: <input type="checkbox"/> Same household <input type="checkbox"/> Coworker <input type="checkbox"/> Healthcare environment <input type="checkbox"/> Other _____	Contact Start: ____ / ____ / ____ m m / d d / y y y y Contact End: ____ / ____ / ____ m m / d d / y y y y
Did the ill <b>contact</b> recently travel to an area with SARS transmission? <i>(see list of areas at end of document)</i>		
If Yes, where? _____		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>Contact Information (3)</b>		
Contact CDC ID: _____ OR Contact STATE ID: _____		
OR <i>(only if ID unavailable)</i> Name of Contact (first, middle initial, last): _____		

**Supplement B: SARS Surveillance**  
(continued from previous page)

Classification of Contact (SEE APPENDIX B1): <input type="checkbox"/> RUI-2 <input type="checkbox"/> RUI-3 <input type="checkbox"/> Probable SARS CoV case <input type="checkbox"/> Confirmed SARS CoV case	Nature of contact: <input type="checkbox"/> Same household <input type="checkbox"/> Coworker <input type="checkbox"/> Healthcare environment <input type="checkbox"/> Other _____	Contact Start: ___ / ___ / ___ m m d d y y y y Contact End: ___ / ___ / ___ m m d d y y y y
Did the ill <b>contact</b> recently travel to an area with SARS transmission? (see list of areas at end of document)  If Yes, where?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

**Travel History**

10. Patient Travel Information			
If recent foreign travel, did the patient receive a <b>Health Alert</b> or other SARS educational information on arrival in the United States?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Was the patient <b>symptomatic</b> during travel from a SARS affected area of within 24 hours of return to the US or local area?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes: 1) Please provide to the CDC the name of the SARS suspect who has traveled (enter name from section 3)			
2) If yes, list all travel either by public conveyance (airplane, train bus) or with a tour group, 24 hours before onset of fever or symptoms and thereafter: List each portion or leg of the trip below:			
Trip or portion (1)			
Departure Date: ___ / ___ / ___ m m d d y y y y	Departure City: _____	Arrival City: _____	Transport Type: <input type="checkbox"/> Airline <input type="checkbox"/> Train <input type="checkbox"/> Cruise <input type="checkbox"/> Bus <input type="checkbox"/> Auto <input type="checkbox"/> Tour Group <input type="checkbox"/> Other
Transport Company:		Transport No:	
Comment:			
Trip or portion (2)			
Departure Date: ___ / ___ / ___ m m d d y y y y	Departure City: _____	Arrival City: _____	Transport Type: <input type="checkbox"/> Airline <input type="checkbox"/> Train <input type="checkbox"/> Cruise <input type="checkbox"/> Bus <input type="checkbox"/> Auto <input type="checkbox"/> Tour Group <input type="checkbox"/> Other

**Supplement B: SARS Surveillance**  
(continued from previous page)

Transport Company:		Transport No:	
Comment:			
<b>Trip or portion (3)</b>			
Departure Date: ____ / ____ / ____ m m d d y y y y	Departure City: _____	Arrival City: _____	Transport Type: <input type="checkbox"/> Auto <input type="checkbox"/> Airline <input type="checkbox"/> Train <input type="checkbox"/> Cruise <input type="checkbox"/> Bus <input type="checkbox"/> Tour Group <input type="checkbox"/> Other
Transport Company:		Transport No:	
Comment:			
<b>Trip or portion (4)</b>			
Departure Date: ____ / ____ / ____ m m d d y y y y	Departure City: _____	Arrival City: _____	Transport Type: <input type="checkbox"/> Auto <input type="checkbox"/> Airline <input type="checkbox"/> Train <input type="checkbox"/> Cruise <input type="checkbox"/> Bus <input type="checkbox"/> Tour Group <input type="checkbox"/> Other
Transport Company:		Transport No:	
Comment:			

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**Classification of Patient**

<b>11. Classification of patient by state of municipality (using CSTE/CDC definitions): SEE APPENDIX B1</b>	
Initial Classification (check one only): <i>Report Under Investigation (RUI)</i> <input type="checkbox"/> RUI-1 <input type="checkbox"/> RUI-2 <input type="checkbox"/> RUI-3 <input type="checkbox"/> RUI-4 OR SARS disease classification <input type="checkbox"/> Probable SARS-CoV Case <input type="checkbox"/> Confirmed SARS-CoV Case	Updated Classification (check one only): <input type="checkbox"/> RUI-1 <input type="checkbox"/> RUI-2 <input type="checkbox"/> RUI-3 <input type="checkbox"/> RUI-4 <input type="checkbox"/> Probable SARS-CoV Case <input type="checkbox"/> Confirmed SARS-CoV Case <input type="checkbox"/> Not a case: negative serology (>28 days post onset) <input type="checkbox"/> Not a case: alternative diagnosis accounts for illness <hr/> Date Updated (most recent): ____ / ____ / ____ m m d d y y y y

**Supplement B: SARS Surveillance**

(continued from previous page)

**Laboratory Evaluation**

12. Local SARS testing		
Chose from the following specimens to enter for each test: Whole blood, serum (acute), serum (convalescent), NP swab, NP aspirate, Broncheoalveolar lavage specimen, OP swab, urine, stool, tissue.		
<b>Specimen 1</b>		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ / __ / ____ m m d d y y y y
Test Requested: <input type="checkbox"/> PCR <input type="checkbox"/> Convalescent serology <input type="checkbox"/> Acute serology <input type="checkbox"/> Culture	Source of Local Testing: <input type="checkbox"/> Public Health Lab <input type="checkbox"/> LRN <input type="checkbox"/> Commercial lab <input type="checkbox"/> other	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Indeterminate
<b>Specimen 2</b>		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ / __ / ____ m m d d y y y y
Test Requested: <input type="checkbox"/> PCR <input type="checkbox"/> Convalescent serology <input type="checkbox"/> Acute serology <input type="checkbox"/> Culture	Source of Local Testing: <input type="checkbox"/> Public Health Lab <input type="checkbox"/> LRN <input type="checkbox"/> Commercial lab <input type="checkbox"/> other	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Indeterminate
<b>Specimen 3</b>		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ / __ / ____ m m d d y y y y
Test Requested: <input type="checkbox"/> PCR <input type="checkbox"/> Convalescent serology <input type="checkbox"/> Acute serology <input type="checkbox"/> Culture	Source of Local Testing: <input type="checkbox"/> Public Health Lab <input type="checkbox"/> LRN <input type="checkbox"/> Commercial lab <input type="checkbox"/> other	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Indeterminate
<b>Specimen 4</b>		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: __ / __ / ____ m m d d y y y y
Test Requested: <input type="checkbox"/> PCR <input type="checkbox"/> Convalescent serology <input type="checkbox"/> Acute serology <input type="checkbox"/> Culture	Source of Local Testing: <input type="checkbox"/> Public Health Lab <input type="checkbox"/> LRN <input type="checkbox"/> Commercial lab <input type="checkbox"/> other	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Indeterminate

**Supplement B: SARS Surveillance**

(continued from previous page)

Specimen 5		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: ____ / ____ / ____ m m d d y y y y
Test Requested: <input type="checkbox"/> PCR <input type="checkbox"/> Convalescent serology <input type="checkbox"/> Acute serology <input type="checkbox"/> Culture	Source of Local Testing: <input type="checkbox"/> Public Health Lab <input type="checkbox"/> LRN <input type="checkbox"/> Commercial lab <input type="checkbox"/> other	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Indeterminate

Specimen 6		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: ____ / ____ / ____ m m d d y y y y
Test Requested: <input type="checkbox"/> PCR <input type="checkbox"/> Convalescent serology <input type="checkbox"/> Acute serology <input type="checkbox"/> Culture	Source of Local Testing: <input type="checkbox"/> Public Health Lab <input type="checkbox"/> LRN <input type="checkbox"/> Commercial lab <input type="checkbox"/> other	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Indeterminate

Specimen 7		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: ____ / ____ / ____ m m d d y y y y
Test Requested: <input type="checkbox"/> PCR <input type="checkbox"/> Convalescent serology <input type="checkbox"/> Acute serology <input type="checkbox"/> Culture	Source of Local Testing: <input type="checkbox"/> Public Health Lab <input type="checkbox"/> LRN <input type="checkbox"/> Commercial lab <input type="checkbox"/> other	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Indeterminate

Specimen 8		
Specimen: _____	If 'Tissue,' specify: _____	Date Collected: ____ / ____ / ____ m m d d y y y y
Test Requested: <input type="checkbox"/> PCR <input type="checkbox"/> Convalescent serology <input type="checkbox"/> Acute serology <input type="checkbox"/> Culture	Source of Local Testing: <input type="checkbox"/> Public Health Lab <input type="checkbox"/> LRN <input type="checkbox"/> Commercial lab <input type="checkbox"/> other	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Indeterminate

13. Alternative Diagnosis	
Was an alternative respiratory pathogen detected?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<i>If yes indicate which one (see list below):</i> _____	

**Supplement B: SARS Surveillance**

(continued from previous page)

Alternative pathogen (e.g., Influenza A, Influenza B, RSV, rhinovirus, adenovirus, *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Mycoplasma*, *Chlamydia pneumoniae*, human parainfluenza virus 1, human parainfluenza 2, human parainfluenza 3, human metapneumovirus, *Legionella* sp., other.):

**14. List specimens sent to the CDC**

Chose from the following specimens to enter below:

Whole blood, plasma, serum (acute), serum (convalescent), NP swab, NP aspirate, bronchoalveolar lavage specimen, OP swab, tracheal aspirate, pleural tap, urine, stool, tissue.

Specimen 1: _____	If 'Tissue', Specify: _____	Date Sent: ___ ___ / ___ ___ / ___ ___ ___ ___ m m   d d   y y y y
Specimen 2: _____	If 'Tissue', Specify: _____	Date Sent: ___ ___ / ___ ___ / ___ ___ ___ ___ m m   d d   y y y y
Specimen 3: _____	If 'Tissue', Specify: _____	Date Sent: ___ ___ / ___ ___ / ___ ___ ___ ___ m m   d d   y y y y
Specimen 4: _____	If 'Tissue', Specify: _____	Date Sent: ___ ___ / ___ ___ / ___ ___ ___ ___ m m   d d   y y y y
Specimen 5: _____	If 'Tissue', Specify: _____	Date Sent: ___ ___ / ___ ___ / ___ ___ ___ ___ m m   d d   y y y y
Specimen 6: _____	If 'Tissue', Specify: _____	Date Sent: ___ ___ / ___ ___ / ___ ___ ___ ___ m m   d d   y y y y
Specimen 7: _____	If 'Tissue', Specify: _____	Date Sent: ___ ___ / ___ ___ / ___ ___ ___ ___ m m   d d   y y y y
Specimen 8: _____	If 'Tissue', Specify: _____	Date Sent: ___ ___ / ___ ___ / ___ ___ ___ ___ m m   d d   y y y y



**Supplement B: SARS Surveillance**

(continued from previous page)

**Note: List of areas with current confirmed or suspected SARS transmission**

*(If SARS-CoV transmission recurs, the list of foreign or domestic areas with documented or suspected recent local transmission of SARS-CoV will be listed here.)*

Types of locations specified will vary (e.g., country, airport, city, building, floor of building). The last date a location may be a criterion for exposure for illness onset is 10 days (one incubation period) after removal of that location from CDC travel alert status. The patient's travel should have occurred on or before the last date the travel alert was in place. Transit through a foreign airport meets the epidemiologic criteria for possible exposure in a location for which a CDC travel advisory is in effect. Information regarding CDC travel alerts and advisories and assistance in determining appropriate dates are available at <http://www.cdc.gov/ncidod/sars/travel.htm>.

For more information, visit [www.cdc.gov/ncidod/sars](http://www.cdc.gov/ncidod/sars) or call the CDC public response hotline at (888) 246-2675 (English), (888) 246-2857 (Español), or (866) 874-2646 (TTY)