Maryland Department of Health and Mental Hygiene
Severe Acute Respiratory Illness Short Form

Please complete form for all patients admitted to pediatric intensive care unit for respiratory illness. The completed form should be faxed to the Maryland Department of Health and Mental Hygiene's Office of Infectious Disease Epidemiology and Outbreak Response at **410-225-7615**.

Today's Date:

Interviewer's name: **County:** **Phone:**

Hospital: _____

Physician: _____ **Phone/Pager:** _____

Patient Demographic Information:

1. **Patient Name:** _____
2. **Sex:** ☐M ☐F
3. **DOB:** ____/____/_____
4. **Age:** ____ ☐yr ☐mo
5. **Ethnicity: Hispanic or Latino?** ☐ Yes ☐ No ☐ Unknown
6. **Race (check all that apply):**
   ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander
   ☐ White ☐ Unknown ☐ Other (specify): _____
7. **Patient Address:**
   Street: _____ Apt: _____
   City/State: _____ Zip: _____ County: _____
8. **Patient phone:** _____
9. **Parent/guardian name:** _____
10. **Parent/guardian phone:** _____

Does the patient have:

1. **Does patient have severe acute respiratory illness (SARI)?** ☐Yes ☐ No
2. **Date of symptom onset:** ____/ ____/ _____
3. **Was patient admitted to ICU?** ☐Yes ☐ No
4. **Has the patient died?** ☐Yes ☐ No
5. **Fever (≥ 38°C, 100.4°F)?** ☐Yes ☐ No ☐ Unknown If yes, maximum temperature? _____
6. **Radiographic evidence of pneumonia or acute respiratory distress syndrome (ARDS)?** ☐ Yes ☐ No ☐ Unknown
   If yes, radiology results:
7. **History of asthma?** ☐ Yes ☐ No ☐ Unknown
8. **Influenza test performed?** ☐ Yes ☐ No ☐ Unknown
   If yes:
   Date of collection: ____/____/_____
   Date of report: ____/____/_____
   Test type: _____
   Test result: ☐ Positive ☐ Negative ☐ Pending ☐ Other (specify):
9. **Enterovirus/rhinovirus test performed?** ☐ Yes ☐ No ☐ Unknown
   If yes:
   Specimen type: _____
   Date of collection: ____/____/_____
   Date of report: ____/____/_____
   Test type: _____
   Test result: ☐ Positive ☐ Negative ☐ Pending ☐ Other (specify):
10. **Specimen submitted to DHMH?** ☐ Yes ☐ No ☐ Unknown
    If yes:
    Specimen type (e.g., NP/OP swab, etc.): _____
    Date of collection: ____/____/_____
    Date submitted: ____/____/_____
11. **Is there alternative diagnosis (i.e., non-enteroviral etiology)?** ☐ Yes ☐ No ☐ Unknown
    If yes, describe: