Severe Pneumonia in Health Care Worker Case Report Form Revised 02/10/2004

Submitted by: **Date of report** (mm/dd/yyyy): ____/____/____

Last name: _____ First name: _____ Phone: (____)_____

Affiliation: _____ State: _____ Email: _____

Patient information

Last name: _____ **First name**: _____ **Case ID: _____**

(Patient identifier information in shaded area is not transmitted to CDC)

Age at onset: _____ years **Sex**: 1 ☐ Male 2 ☐ Female

State of current residence: (pick list) **County**: _____

City: _____ **Phone number**: (____)_____

Ethnicity:
1☐ Hispanic or Latino
2☐ not Hispanic or Latino
9☐ Unknown

Race (check all that apply):
1☐ American Indian/Alaskan Native
1☐ Asian
1☐ Black
1☐ Native Hawaiian/Other Pacific Islander
1☐ White
1☐ Other
1☐ Unknown

U.S. Citizen? 1 ☐ Yes 2 ☐ No (please fill in nationality/citizenship): _____

Residency: 1☐ U.S. 2 ☐ non-U.S.

Occupation of healthcare worker:
1☐ administrative
2☐ housekeeping
3☐ laboratory staff
4☐ nurse
5☐ nurse's aide
6☐ physician, specialty: _____
7☐ physician's assistant
8☐ nurse practitioner
9☐ phlebotomist
10 ☐ radiology technician
11 ☐ respiratory therapist
12 ☐ transport
13 ☐ other: _____

Does patient have DIRECT patient care responsibilities? 1☐ Yes 2 ☐ No 9 ☐ Unknown

Place of employment (check all that apply):
1☐ ambulatory care facility
1☐ hospital
1☐ long-term care facility
1☐ clinical laboratory
1☐ other: _____

Name of institution where employed: *(pick list of healthcare facilities if customized for each site)*

OR **Institutional ID: _____** **City**: _____ **State**: (pick list)

Clinical information

Date of symptom onset (mm/dd/yyyy): ____/____/____

Did the person have a fever (subjective or objective)? 1☐ Yes 2 ☐ No 9 ☐ Unknown
If yes, date of fever onset (mm/dd/yyyy): ____/____/____
Was temperature >38°C (100.4°F)? 1 ☐ Yes 2 ☐ No 3 ☐ Subjective fever only 9 ☐ Unknown

Did the patient have any lower respiratory symptoms (e.g. cough, shortness of breath, difficulty breathing)? 1☐ Yes 2 ☐ No 9 ☐ Unknown

Date of first health care evaluation for this illness (mm/dd/yyyy): ____/____/____

Current hospitalization:

Date of admission (or transfer from another facility) (mm/dd/yyyy): ____/____/____

Hospital ID #: _____ *OR* Hospital name: _____

City: _____ State: (pick list)

Was the patient hospitalized elsewhere and then transferred to this facility?

1☐ Yes 2☐ No 9☐ Unknown

If yes:

Hospital ID #: _____ *OR* Hospital name: _____

City of previous hospitalization: _____ State: (pick list)

Date of admission to initial facility (mm/dd/yyyy): ____/____/____

Was the patient ever admitted to intensive care unit? 1☐ Yes 2☐ No 9☐ Unknown

Was the patient placed on mechanical ventilation? 1☐ Yes 2☐ No 9☐Unknown

If yes, for how many days? 1☐ <24 hours
2☐ 1-2 days
3☐ 3-4 days
4☐ 5-6 days
5☐ ≥ 7days

At time of report, clinical status of patient:

1☐ inpatient
2☐ discharged …….. Date of discharge: *(mm/dd/yyyy)* ____/____/____
3☐ transferred to another facility … Date of transfer: *(mm/dd/yyyy)* ____/____/____
4☐ left against medical advice
5☐ deceased …… Date of death: *(mm/dd/yyyy)* ____/____/____
9☐ unknown

If **deceased:** Did patient die as a result of this illness? 1☐ Yes 2☐ No 9☐Unknown
Was an autopsy performed? 1☐ Yes 2☐ No 9☐Unknown
If yes, what was the cause of death based on autopsy? _____
Was pathology consistent with pneumonia or respiratory distress syndrome?
1☐ Yes 2☐ No 9☐ Unknown

Past medical history	
Chronic metabolic or renal disease (e.g. diabetes)	1☐Yes 2☐ No 9☐Unknown
Chronic lung disease (including asthma)	1☐Yes 2☐ No 9☐Unknown
Chronic cardiovascular disease	1☐Yes 2☐ No 9☐Unknown
Hemoglobinopathy	1☐Yes 2☐ No 9☐Unknown
Immunosuppressive conditions (e.g. chronic steroid use)	1☐Yes 2☐ No 9☐Unknown
Currently smokes?	1☐Yes 2☐ No 9☐Unknown
Received influenza vaccine for this season?	1☐Yes 2☐ No 9☐Unknown
If yes, date (mm/yyyy): ____/____	
Has the patient had a tuberculin skin test?	1☐ Yes 2 ☐ No 9 ☐ Unknown
If yes, what was the most recent result?	1☐ Positive 2 ☐ Negative 9 ☐ Unknown
Date (mm/yyyy): ____/____	
If positive, did the patient have a chest x-ray?	1☐ Yes 2☐ No 9 ☐ Unknown
If yes, what was the CXR result?	1☐ Normal 2☐ Abnormal 9 ☐ Unknown
Date (mm/yyyy): ____/____	
Did patient receive prophylaxis for latent TB infection?	1☐ Yes 2☐ No 9 ☐ Unknown

Diagnostic information

Was a chest x-ray performed? 1☐Yes 2 ☐No 9☐ Unknown

If yes, and result is **normal**, date of most recent normal result: *(mm/dd/yyyy)* ____/____/____

If yes, and result is **abnormal**, date of first abnormal result: *(mm/dd/yyyy)* ____/____/____

If abnormal, check all that apply:

1☐Interstitial infiltrate 1☐ Lobar infiltrate 1☐ Lobar consolidation
1☐ Pleural effusion 1☐ Hilar adenopathy 1☐ Other (describe) _____

Was a chest CT scan performed? 1☐ Yes 2 ☐ No 9 ☐ Unknown

If yes, and result is **normal**, date of most recent normal result: *(mm/dd/yyyy)* ____/____/____

If yes, and result is **abnormal**, date of first abnormal result: *(mm/dd/yyyy)* ____/____/____

If abnormal, check all that apply:

1☐ Interstitial infiltrate 1☐ Lobar infiltrate 1☐ Lobar consolidation
1☐ Pleural effusion 1☐ Hilar adenopathy 1☐ Other (describe) _____

Was the white blood cell count ever lower than 4.5 x 10^9/L? 1 ☐ Yes 2 ☐No 9 ☐ Unknown

Has an etiology for the patient's illness been determined? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If yes, please check: *(pick list?)* Other (describe) _____

Please indicate results for following tests for respiratory pathogens :

Blood culture : 1☐ Positive 2 ☐ Negative 3 ☐ Not done 9 ☐ Unknown

If negative (i.e., never *any* positive result), date of most recent negative: ____/____/____

If positive, organism(s) isolated and date of first positive:

(Organism 1) _____ *(mm/dd/yyyy)* ____/____/____
(Organism 2) _____ *(mm/dd/yyyy)* ____/____/____
(Organism 3) _____ *(mm/dd/yyyy)* ____/____/____

Sputum culture: 1☐ Positive 2☐ Negative 3☐ Not done 9☐ Unknown

If negative, date of most recent negative: *(mm/dd/yyyy)* ____/____/____

If positive, organism(s) isolated and date of first positive:

(Organism 1) _____ *(mm/dd/yyyy)* ____/____/____
(Organism 2) _____ *(mm/dd/yyyy)* ____/____/____
(Organism 3) _____ *(mm/dd/yyyy)* ____/____/____

Rapid influenza A/B test: 1☐ Positive 2 ☐ Negative 3 ☐ Not done 9 ☐ Unknown

Date of first positive (mm/dd/yyyy): ____/____/____
If negative, date of most recent negative: ____/____/____

Rapid RSV test: 1☐ Positive 2 ☐ Negative 3 ☐ Not done 9 ☐ Unknown

Date of first positive (mm/dd/yyyy): ____/____/____
If negative, date of most recent negative: ____/____/____

***S. pneumoniae* urine antigen**: 1☐ Positive 2 ☐ Negative 3 ☐ Not done 9☐ Unknown

Date of first positive (mm/dd/yyyy): ____/____/____
If negative, date of most recent negative: ____/____/____

***Legionella* urine antigen**: 1☐ Positive 2 ☐ Negative 3 ☐ Not done 9 ☐ Unknown

Date of first positive (mm/dd/yyyy): ____/____/____
If negative, date of most recent negative: ____/____/____

***Legionella* DFA**: 1☐ Positive 2 ☐ Negative 3 ☐ Not done 9 ☐ Unknown
Date of first positive (mm/dd/yyyy): ____/____/____
If negative, date of most recent negative: ____/____/____

***Legionella* serology**: 1☐ Positive 2 ☐ Negative 3 ☐ Not done 9 ☐ Unknown
Date of first positive (mm/dd/yyyy): ____/____/____
If negative, date of most recent negative: ____/____/____

For any other microbiology tests for respiratory pathogens, please specify:

Name of pathogen	Source of specimen	Result	Date of specimen collection
1.			
2.			
3.			

COMMENT SECTION

Completion of only ONE of the two following sections is necessary. These additional questions pertain to **contact** with other persons with pneumonia and recent **travel**.

Option A: For cases not reported to the SARS Surveillance System, limited questions on contact with other persons with respiratory disease and recent travel.
Option B: Contact and travel questions for cases required to be reported to CDC's SARS Surveillance System.

Question: What type of cases needed to be reported to CDC's SARS Surveillance System?
In the current setting of no SARS transmission in the world, the only ill persons who should be reported to CDC are those who meet one of the two case definitions for SARS-CoV disease: **probable** case of SARS-CoV disease, or **confirmed** case of SARS-CoV disease. The revised SARS case classification can be found at the following website: http://www.cdc.gov/ncidod/sars/casedefinition.htm). These case definitions are restricted to patients who have an epidemiologic link to a lab-confirmed SARS-CoV case or to patients who themselves have a laboratory-confirmed diagnosis.

If SARS-CoV disease transmission should recur in the world, it is possible that persons who do not meet the case definition of "probable case of SARS-CoV disease" or "confirmed case of SARS-CoV disease" but who are considered a "Report Under Investigation" (see SARS case definition) will be required to be reported to CDC. This decision will be made following discussions with CSTE and then distributed to state and local public health officials.

OPTION A: FOR CASES NOT REPORTED TO SARS SURVEILLANCE SYSTEM

SECTION I: Travel History

Did the patient travel outside state of residence (foreign or domestic travel) within 30 days of symptom onset? 1☐ Yes 2 ☐ No 9 ☐ Unknown
If yes, please give location and dates of travel:

Departure city: _____ Date of departure: *(mm/dd/yyyy)* ____/____/____
Arrival city: _____ Date of arrival: *(mm/dd/yyyy)* ____/____/____
Mode of transportation: pick list (airplane, train, auto, cruise, bus, other)

Departure city: _____ Date of departure: *(mm/dd/yyyy)* ____/____/____
Arrival city: _____ Date of arrival: *(mm/dd/yyyy)* ____/____/____
Mode of transportation: picklist (airplane, train, auto, cruise, bus, other)

Departure city: _____ Date of departure: *(mm/dd/yyyy)* ____/____/____
Arrival city: _____ Date of arrival: *(mm/dd/yyyy)* ____/____/____
Mode of transportation: pick list (airplane, train, auto, cruise, bus, other)

SECTION II: Contact History

In the 10 days prior to onset of symptoms, did the patient have close contact with any person who had been hospitalized for a respiratory illness?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If yes, please give contact information:

Last name: _____ First name: _____
City: _____ State: (pick list) Country: _____
Phone number:_____-_____-_____

Name of hospital: _____
City: _____ State: (pick list) Country: _____

Dates of admission and discharge (if applicable) (mm/dd/yyyy):
Admitted: ____/____/____ Discharged: ____/____/____

Last name: _____ First name: _____
City: _____ State: (pick list) Country: _____
Phone number:_____-_____-_____

Name of hospital: _____
City: _____ State: (pick list) Country: _____

Dates of admission and discharge (if applicable) (mm/dd/yyyy):
Admitted: ____/____/____ Discharged: ____/____/____

OPTION B: EPIDEMIOLOGIC RISK FACTORS FOR SARS-COV

SARS SECTION I: 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? ***** **** See SARS case definitions for classifications***	☐ Yes **If yes, complete Option B: section II** ☐ No ☐ Unknown
B. Close contact with a person considered an RUI-2 or RUI-3? ***** **** See SARS case definitions for classifications***	☐ Yes **If yes, complete Option B: section II** ☐ No ☐ Unknown

C. Travel to **foreign** or **domestic** area with documented or suspected recent local transmission of SARS cases?

□ Yes
If yes, **enter destination below**
□ No
□ Unknown

Destination: _____
Date of Arrival: *(mm/dd/yyyy)* ___/____/____ Date of Departure: *(mm/dd/yyyy)* ____/____/____

Destination: _____
Date of Arrival: *(mm/dd/yyyy)* ___/____/____ Date of Departure: *(mm/dd/yyyy)* ____/____/____

Destination: _____
Date of Arrival: *(mm/dd/yyyy)* ___/____/____ Date of Departure: *(mm/dd/yyyy)* ____/____/____

Destination: _____
Date of Arrival: *(mm/dd/yyyy)* ___/____/____ Date of Departure: *(mm/dd/yyyy)* ____/____/____

SARS Section II: Contact History

*Add Contact information **for ill contacts** identified by question IA or IB 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.*

Contact Information (1)

Contact CDC ID: **OR** Contact STATE ID: _____
_____
OR *(only if ID unavailable)* Name of Contact (first, middle initial, last):_____

Classification of Contact **(See SARS case classification):**	Nature of contact:	Contact Start: *(mm/dd/yyyy)* ____/____/____
□ RUI-2 □ RUI-3 □ Probable SARS CoV case □ Confirmed SARS CoV case	□ Same household □ Coworker □ Healthcare environment □ Other _____	Contact End: *(mm/dd/yyyy)* ____/____/____

Did the **ill contact** recently travel to an area with SARS transmission? □Yes □No □Unknown

If Yes, where? _____

Contact Information (2)

Contact CDC ID: **OR** Contact STATE ID: _____
_____
OR *(only if ID unavailable)* Name of Contact (first, middle initial, last):_____

Classification of Contact **(See SARS case classification):**	Nature of contact:	Contact Start: *(mm/dd/yyyy)* ____/____/____
□ RUI-2 □ RUI-3 □ Probable SARS CoV case □ Confirmed SARS CoV case	□ Same household □ Coworker □ Healthcare environment □ Other _____	Contact End: *(mm/dd/yyyy)* ____/____/____

Did the **ill contact** recently travel to an area with SARS transmission? □Yes □No □Unknown

If Yes, where? _____

Contact Information (3)

Contact CDC ID: **OR** Contact STATE ID: _____

_____

OR *(only if ID unavailable)* Name of Contact (first, middle initial, last):_____

Classification of Contact **(See SARS case classification):**	Nature of contact:	Contact Start: *(mm/dd/yyyy)* ____/____/____
□ RUI-2 □ RUI-3 □ Probable SARS CoV case □ Confirmed SARS CoV case	□ Same household □ Coworker □ Healthcare environment □ Other _____	Contact End; *(mm/dd/yyyy)* ____/____/____

Did the **ill contact** recently travel to an area with SARS transmission? □ Yes □ No □ Unknown

If Yes, where? _____

SARS Section III: Patie nt Travel Information

Is there history of foreign travel in the 10 days prior to symptom onset? □ Yes □ No □ Unknown

If No or Unknown, this is the end of data entry.

If history of foreign travel in past 10 days, did the patient receive a **Health Alert** or other SARS educational information on arrival in the United States? □ Yes □ No □ Unknown

Was the patient **symptomatic** during travel from a SARS affected area or within 24 hours of return to the US or local area? □ Yes □ No □ Unknown

If yes:

1) Please provide to the CDC the name of the SARS suspect who has traveled *(enter name from section III)*

2) Please 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 or the trip below:

Trip or portion (1)

Departure Date: *(mm/dd/yyyy)* ____/____/____	Departure City: _____	Arrival City: _____	Transport Type: □ Airline □ Auto □ Train □ Tour □ Cruise Group □ Bus □ Other

Transport Company: Transport No:

Comment:

Trip or portion (2)

Departure Date: *(mm/dd/yyyy)* ____/____/____	Departure City: _____	Arrival City: _____	Transport Type: □ Airline □ Auto □ Train □ Tour □ Cruise Group □ Bus □ Other

Transport Company: Transport No:

Comment:

Trip or portion (3)

Departure Date: *(mm/dd/yyyy)* ____/____/____	Departure City: _____	Arrival City: _____	Transport Type: □ Airline □ Auto □ Train □ Tour □ Cruise Group □ Bus □ Other

Transport Company: Transport No:

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<tr><td colspan="4">Trip or portion (4)</td></tr>
<tr><td>Departure Date:
(mm/dd/yyyy)
____/____/____</td><td>Departure City:

_____</td><td>Arrival City:

_____</td><td>Transport Type:
☐ Airline ☐ Auto
☐ Train ☐ Tour
☐ Cruise Group
☐ Bus ☐ Other</td></tr>
<tr><td colspan="2">Transport Company:</td><td colspan="2">Transport No:</td></tr>
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