Form Approved
OMB NO. 0920-0596
Exp. Date ______

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Centers for Disease Control and Prevention (CDC)
Atlanta GA 30333

Version 3-27-03 12:00

International SARS Case Report Form

1. Name/affiliation of person filling out form		Patient ID # (*if any)*				
Date of Report:	MM	DD	2003	**Time of Report:**	:	AM PM

2. Followup Contact Information	Last Name:	First Name:		**Country:**	
Phone: ( )	Email:	Other ( )	☐ Phone / ☐ Fax	Other ( )	☐ Phone / ☐ Fax

3. Reporter or Clinician Contact	Last Name:		First Name:		
Hospital or Clinic Name:				City:	
Country	Province:				
Phone: ( )	Email:	Other ( )	☐ Phone / ☐ Fax	Other ( )	☐ Phone / ☐ Fax

4. Patient Information	Last Name:		First Name:		
City of residence:	Province of residence:	Country of Residence:	Nationality: ___________		
Date of Birth: MM DD YYYY		Age _____	☐ Years ☐ Months	Sex	☐ Male ☐ Female

5. Occupation	Healthcare worker?	☐ Yes ☐ No	*If yes, specify* ☐ Physician ☐ Nurse/PA ☐ Laboratory ☐ **Other:** ______________________
If not a healthcare worker, list occupation:			

6. Signs and Symptoms	Date of symptom onset	MM	DD	YYYY

Check all signs and symptoms that apply

☐ Temperature > 38°C (100.4°F)	Highest Temperature _____	☐°C ☐°F	☐ Cough	☐ Shortness of breath/ difficulty breathing
☐ Pneumonia ☐ Radiographic evidence of Pneum.		☐ Respiratory Distress Syndrome—(ARDS)		
☐ Other symptoms or relevant findings, ***List:***				

7. Clinical status at the time of report		☐ Outpatient ☐ Discharged ☐ Inpatient ☐ Died ☐ Unknown			
Was Patient Hospitalized?	☐ Yes ☐ No ☐ Unknown	Was patient placed on mechanical ventilation?	☐ Yes ☐ No ☐ Unknown	Is patient currently on mechanical ventilator?	☐ Yes ☐ No ☐ Unknown

Date of Hospitalization:	MM	DD	YY	**Date of Discharge or Death**	MM	DD	YY

Name of Hospital:	**City:**	**Country:**	**Phone number:**

Public reporting burden of this collection of information is estimated to average X minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

If patient died: Was an autopsy performed?	☐ Yes ☐ No ☐ Unk	Was pathology consistent with Respiratory Distress Syndrome?	☐ Yes ☐ No ☐ Unk

Was pathology consistent with Respiratory Distress Syndrome?

What was the cause of death based on autopsy? ___________________________ ☐ Unknown

8. Diagnostic evaluation:	Has an etiology for patient's illness been determined? ***If yes***: list: ___________________________	☐ Yes ☐ No

Please fill in results of any tests that have been performed at this time:

☐ Blood culture(s) ☐ Positive ☐ Negative ☐ Pending **Comment/Result:**_______________

☐ Sputum gram stain ☐ Positive ☐ Negative ☐ Pending **Comment/Result:**_______________

☐ Rapid Influenza test ☐ Positive ☐ Negative ☐ Pending **Comment/Result:**_______________

☐ Resp Sync Virus ☐ Positive ☐ Negative ☐ Pending **Comment/Result:**_______________

9. Other pertinent clinical information and laboratory tests:

☐ Lowest **WBC** Count: _______________ ☐ Lowest **Platelet** Count:_______________

☐ Highest **CPK** : _______________ ☐ Lowest Absolute lymphoctye count : _______________

☐ Highest **AST** : _______________

☐ Highest **ALT** : _______________

Needed Supplemental Oxygen? ☐ Yes ☐ No

10. Travel History	Did patient travel to any the following destinations within 10 days of symptom onset? ☐ Yes, ***specify below*** ☐ No ☐ Unknown travel history

☐ Hong Kong
☐ Guangdong Province, People's Rep. of China
☐ Hanoi, Vietnam
☐ Singapore
☐ Toronto, Canada
☐ Other _______________ City/State/Country

11. Exposure History	Indicate if the patient was one or more of the following :	☐ Health Care worker ☐ Household Contact of SARS Case ☐ Friend of SARS Case ☐ Guest at a hotel where other SARS patients stayed ☐ Other ☐ Unknown

Notes: (Dates of contact with SARS patients if known)

12. FOR CDC use only : Meets Suspect Case Definition: ☐ Yes ☐ No **CDC ID#**

Completed forms should be faxed to the CDC Emergency Operations Center at 1-770-488-7107.