

### Hantavirus Pulmonary Syndrome Case Report Form

Please return with Diagnostic Specimen Submission Form to:  
 Special Pathogens Branch c/o DASH  
 1600 Clifton Rd. NE, Bldg 4, Rm. B-35  
 Atlanta, GA 30329-4018 Ph: 404-639-1510 Fax: 404-639-1509

### Patient Identification

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-FIPS-    -YR-

Information below is required for identification and meaningful interpretation of laboratory diagnostic results.  
 HPS may not be confirmed without compatible clinical and/or exposure data.

Patient's last name	First name	Middle initial
Street Address	City	County
	State	Zip
Age: _____ Sex: Male _____ Female _____ Occupation: _____		
Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____ Unk _____		
Race: American Indian/Alaska Native _____ Asian _____ Black or African American _____ Native Hawaiian or Other Pacific Islander _____ White _____		
History of any rodent exposure in 6 weeks prior to onset of illness? Yes _____ No _____ Unk _____		
If yes, type of rodent: Mouse _____ Rat _____ Other _____ Rodent nest _____ Unk _____		
Place of contact (town, county, state): _____		

Symptom onset date:
Specimen acquisition date:

**Signs and Symptoms:**

Fever > 101 °F or > 38.3 °C	Yes _____ No _____ Unk _____
Thrombocytopenia (platelets ≤ 150,000/mm <sup>3</sup> )	Yes _____ No _____ Unk _____
Elevated Hematocrit (Hct)	Yes _____ No _____ Unk _____
Elevated creatinine	Yes _____ No _____ Unk _____

WBC Total: \_\_\_\_\_ Total Neutrophils: \_\_\_\_\_% Band Neutrophils: \_\_\_\_\_% Lymphocytes: \_\_\_\_\_%

Supplemental oxygen required?	Yes _____ No _____ Unk _____
Was patient intubated?	Yes _____ No _____ Unk _____
CXR with unexplained bilateral interstitial infiltrates or suggestive of ARDS?	Yes _____ No _____ Unk _____

Outcome of illness?	Alive _____ Dead _____ Unk _____
Was an autopsy performed?	Yes _____ No _____ Unk _____

Has specimen been tested for hantavirus at another laboratory? Yes \_\_\_\_\_ No \_\_\_\_\_ Unk \_\_\_\_\_  
 If yes, where? \_\_\_\_\_ Type of specimen? \_\_\_\_\_ Results (i.e. titer, OD) \_\_\_\_\_

State Health Dept. reporting case: \_\_\_\_\_ State/Local ID number: \_\_\_\_\_ Date form completed: \_\_\_\_\_  
 Person completing report: \_\_\_\_\_ Phone number \_\_\_\_\_  
 Name of patients's physician: \_\_\_\_\_ Phone number \_\_\_\_\_  
 Centers for Disease Control and Prevention                      Unk=Unknown

Public reporting burden of this collection of information is estimated to average 20 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-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0009).