

### 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).