

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/mm³) 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).