

Middle East Respiratory Syndrome Coronavirus (MERS) Patient Under Investigation (PUI) Form

Form Approved OMB 0920-0004, Exp Date 08/31/2014

For PUI, complete and send this form to eocevent90@cdc.gov (subject line: MERS Form) or fax to 770-488-7107.

If you have questions contact the CDC Emergency Operations Center (EOC) at 770-488-7100.

STATE ID:	Today's Date: MM/DD/YY	County:	City:	State:
Interviewer's name:	Phone:	Email:		
Physician's name:		Phone/Pager:		
PUI Definition—Does the patient have: (Please consult CDC website at http://www.cdc.gov/coronavirus/mers/case-def.html)				
1. Acute respiratory infection with fever ($\geq 38^{\circ}\text{C}$, 100.4°F) and cough? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
2. Clinical or radiographic evidence of pneumonia or acute respiratory distress syndrome (ARDS)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
3. Travel from the Arabian Peninsula or neighboring countries [†] 14 days before illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
If yes, which countries? _____ Date of travel to/from the Middle East: MM/DD/YY MM/DD/YY				
Patient Demographic Information				
1. Sex: <input type="checkbox"/> M <input type="checkbox"/> F 2. Age: _____ <input type="checkbox"/> yr <input type="checkbox"/> mo 3. Residency: <input type="checkbox"/> US resident <input type="checkbox"/> non US resident, country: _____				
Clinical Presentation, History and Risk Factors				
4. Date of symptom onset: MM/DD/YY				
5. Symptoms (Check all that apply): <input type="checkbox"/> Fever <input type="checkbox"/> Dry cough <input type="checkbox"/> Productive cough <input type="checkbox"/> Chills <input type="checkbox"/> Sore throat <input type="checkbox"/> Headache <input type="checkbox"/> Muscle aches <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other _____				
6. In the 14 days before symptom onset did the patient have close contact with a recent ill traveler from the Arabian Peninsula or neighboring countries [†] ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, which countries? _____				
7. Is the patient (Check all that apply): <input type="checkbox"/> Health care worker (HCW) <input type="checkbox"/> US military <input type="checkbox"/> Flight crew <input type="checkbox"/> Other _____				
8. Concurrent risk factors (Check all that apply): <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Pregnant <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____				
Clinical Outcomes				
9. Is/Was the patient:			10. Is/Has patient receiving/received a diagnosis of:	
a. Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date: MM/YY/DD			Pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
b. Admitted to ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			ARDS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
c. Intubated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Renal failure? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
11. Does the patient have a non-MERS etiology for their respiratory illness but has not responded to appropriate therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			12. Has the patient died? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Infection Control				
13. When hospitalized, is/was the patient in a:			14. Are/Were surgical masks being used by the patient during transport?	
a. Negative pressure room? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
b. Private room? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
15. What personal protective equipment are/were being used by HCW when entering the patient's room (Check all that apply): <input type="checkbox"/> Gloves <input type="checkbox"/> Gowns <input type="checkbox"/> Eye protection (goggles or face shield) <input type="checkbox"/> N95/other form of respiratory protection (e.g., PAPR) <input type="checkbox"/> Facemask <input type="checkbox"/> Unknown				

Laboratory Testing									
Tests Performed	Results				Tests Performed	Results			
	+	⊖	Pending (Pe)	Not done		+	⊖	Pending (Pe)	Not done
Influenza <input type="checkbox"/> A <input type="checkbox"/> B			<input type="checkbox"/>	<input type="checkbox"/>	Streptococcus pneumoniae			<input type="checkbox"/>	<input type="checkbox"/>
RSV			<input type="checkbox"/>	<input type="checkbox"/>	Legionella pneumophila			<input type="checkbox"/>	<input type="checkbox"/>
Human metapneumovirus			<input type="checkbox"/>	<input type="checkbox"/>	Blood culture			<input type="checkbox"/>	<input type="checkbox"/>
Parainfluenza 1-4			<input type="checkbox"/>	<input type="checkbox"/>	If positive _____			<input type="checkbox"/>	<input type="checkbox"/>
Adenovirus			<input type="checkbox"/>	<input type="checkbox"/>	Other: _____			<input type="checkbox"/>	<input type="checkbox"/>

MERS Testing													
Specimen [†]	ID #	Date collected	State			Sent to CDC?	Specimen [†]	ID #	Date collected	State			Sent to CDC?
			+	⊖	Pe					+	⊖	Pe	
NP/OP		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>	PF		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>
Sputum		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>	Stool		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>

[†]Countries considered in the Arabian Peninsula and neighboring include: Bahrain, Iraq, Iran, Israel, Jordan, Kuwait, Lebanon, Oman, Palestinian territories, Qatar, Saudi Arabia, Syria, the United Arab Emirates (UAE), and Yemen.

Public reporting burden of this collection of information is estimated to average 25 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0004).

BAL		MM/DD/YY		<input type="checkbox"/>	<input type="checkbox"/>	Serum		MM/DD/YY		<input type="checkbox"/>	<input type="checkbox"/>
TA		MM/DD/YY		<input type="checkbox"/>	<input type="checkbox"/>			MM/DD/YY		<input type="checkbox"/>	<input type="checkbox"/>

‡NP/OP, Nasopharyngeal/Oropharyngeal swab; BAL, Bronchoalveolar lavage; TA, Tracheal aspirate; PF, Pleural fluid