

Questionnaire for Passengers and Crew
MERS-CoV Aircraft Contact Investigation

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 (0920-1011)

A. Demographic Information

10. Age: _____ years / months (circle one)
 11. Sex (circle one): M F

B. Flight History for Passenger (for crew member, skip to Section C)

The airline(s) has/have indicated that you were a passenger on the following flight(s). The next set of questions pertain to that/those specific flight(s).

Questions 12-14 should be repeated for each flight, as applicable

NOTE: If passenger was not on any of the above flights, the interview is completed.

Questions for Flight(s)

12a. Confirm passenger traveled on [check flight(s) below]

- | | | | |
|--|------------------------------|-----------------------------|---------------------------------|
| <input type="radio"/> Flight Leg A, May 1 st , 2014 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| <input type="radio"/> Flight Leg B, May 1 st , 2014 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| <input type="radio"/> Flight Leg C, May 1 st , 2014 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| <input type="radio"/> Flight Leg D, May 1 st , 2014 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |

If NO or unsure, provide code share info. Check other flights. If not on any of the flights, then the interview is complete.

If YES,

13a: Did you sit in your assigned seat for this entire flight ?

- Yes – **Skip to Question 14a** No Don't remember

13a.1. If no, how long did you sit in your assigned seat?

- <30 minutes 30-60 minutes > 60 minutes Don't remember

13a.2. What other seat number did you sit in for all or part of the flight?

Seat Number: _____ Don't remember

13a.3. If passenger doesn't remember which seat number, ask to describe which part of the plane she or he sat in. _____

13a.4. How long did you sit in this other seat?

- <30 minutes 30-60 minutes > 60 minutes Don't remember

14a. Were you traveling with anyone else on this flight?

- Yes –complete table below No – Skip to Question 14b

14.a.1. Who did you travel with? [This information will help make sure we can contact her or him about possible exposure during the flight.]

Name (last, first)	Relation*	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

*A. friend B. colleague C. household member** D. non-household family member

** If household member(s), ask to interview that person when done with this interview

14b. Did you come into contact with anyone who seemed ill with respiratory symptoms (such as cough or difficulty breathing) or appeared feverish? Yes No

14c. Did you assist them in any way? If yes, please explain.

C. Flight History for Crew Member (For passenger, skip to Section D)

15. Confirm that crew member worked on

- | | | | |
|--|------------------------------|-----------------------------|---------------------------------|
| <input type="radio"/> Flight Leg A, May 1 st , 2014 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| <input type="radio"/> Flight Leg B, May 1 st , 2014 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| <input type="radio"/> Flight Leg C, May 1 st , 2014 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| <input type="radio"/> Flight Leg D, May 1 st , 2014 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |

IF NO, interview is complete. Thank the person for her/his time.

If YES, continue

16. Crew type (circle all that apply) or Cabin for passenger

- Flight Deck: Captain
 First Officer
 Flight engineer/ navigator
 Other (such as jumpseater; specify): _____
- Cabin: First Class
 Business Class

Economy Class(specify section if assigned to a specific one): _____

Lead Flight Attendant

17. Did you come into contact with anyone who seemed ill with respiratory symptoms (such as cough or difficulty breathing) or appeared feverish? Yes No

18. Did you assist them in any way? If yes, please explain.

D. Illness and Medical History

19. Have you been ill since the day of the flight? Yes No

IF YES, GO TO 20. IF NO, GO TO APPENDIX I (SEROLOGY). THEN...

- Read end script for asymptomatic contact.
- Send Information Notice to traveler by e-mail or fax.

20. Have you had any of the following symptoms since your flight?

a. **Fever (measured temp of > 100.4⁰ F (38⁰ C)**

Yes (Temp if known _____°) No Don't Know

b. **Coughing** Yes No Don't Know

c. **Difficulty breathing or shortness of breath** Yes No Don't Know

d. **Wheezing** Yes No Don't Know

e. **Pain with coughing or breathing** Yes No Don't Know

f. **Other symptom(s):** Yes; List: _____ No Don't Know

IF NO/DON'T KNOW TO 20 a-e, GO TO APPENDIX I (SEROLOGY). THEN...

- Read end script for asymptomatic contact.
- Send **Informational Notice for MERS-CoV Exposure on Airplane** to traveler by e-mail or fax.

21. What date did you first become ill with these symptoms? (Date : ____/____/14)

If sick on or before date of flight, complete interview, then consult medical officer before giving advice to patient.

22. Are you still sick? Yes No

22a. If NO, when did you feel better? Date __/__/14

23. Did you see a doctor for this illness? Yes No

If YES,

- a. What date were you seen? Date ___/___/14
- b. Did you receive any treatment for the illness? Yes No
 - i. If YES, specify: _____
- c. Were you tested by a medical provider for the illness (including, but not limited to, providing a blood sample, or nasal or throat swab) since the day of your flight? Yes No
 - i. If YES – Specify test or what kind of specimen was tested for you (e.g., blood, nasal swab, throat swab.): _____
 - 1. Date (mm/dd/yy) ___/___/14
 - 2. Facility where tested _____
- d. Were you admitted to the hospital (kept overnight, not just in emergency room)? YES/NO If yes, which hospital? _____

24. Do you have any medical conditions that you are treated for regularly?
 Yes (Specify: _____) No Don't Know

25. For women: Are you currently pregnant? Yes No Don't Know

E. GEOGRAPHIC EXPOSURES

26. Have you visited the Middle East since April 17th?
 Yes No **If NO, skip to Question 28.**
- a. If YES : Dates of visit (mm/dd/yy) ___/___/14 to ___/___/14
 - b. List country(ies): _____
 - c. (Omit for crew) What was the purpose of your trip? (check all that apply)
 - Visit family/friends Personal travel Business Study Other, specify _____

27. While you were in the Middle East, did you:
- a. Have any close contact with someone who was sick with MERS-Coronavirus?
 Yes No
 - b. Have any close contact with someone who was sick with a serious respiratory infection, such as pneumonia? Yes No

c. Visit a health care facility? Yes No

d. (Omit for crew) Work in a health care facility? Yes No

e. Have any animal exposures? Yes No

If yes: name animals

1: _____ (describe) _____, date: ____/____/____

2: _____ (describe) _____, date: ____/____/____

3: _____ (describe) _____, date: ____/____/____

F. Household Contacts

28. Has anyone in your household or someone else you have had close contact with had fever, cough, difficulty breathing, or other symptoms similar to what you described?

Yes *** No Don't Know (***) Note this person's name and contact information on the form for follow-up by local health department.)

1. Name(s): _____

Relationship: _____

Symptoms: _____

Date of onset (mm/dd/yy) ____/____/____

Address: _____

Phone #: _____

2. Name: _____

Relationship: _____

Symptoms: _____

Date of onset (mm/dd/yy) ____/____/____

Address: _____

Phone #: _____

Serology Consent/Assent Script for Asymptomatic Passengers and Crew

As part of our contact investigation we are asking passengers and crew to get a blood test for MERS.

The test will help tell us if some people exposed to MERS can be infected without showing symptoms. This would involve drawing a small amount of blood (for adults 1 teaspoon, for infants or young children half a teaspoon or less). There will be no cost to you for doing this testing. Drawing blood can cause some pain, bruising or a small amount of bleeding at the site of the blood draw, and can make some people feel lightheaded.

We will give you the results of the test, but they will not be available in time to make any decisions about your health care. Leftover blood will be stored at CDC and might be used for MERS testing in the future, such as developing new tests for MERS infection. If you agree to do the blood test, we will follow up with you at a later date (in approximately 2-3 weeks) with more details about how and where to have your blood drawn.

Do you have any questions?

Would you be willing to let us do a MERS blood test? Yes No

If NO: thank the person for their time.

Chart Abstraction Form – Legionnaires' Disease

SECTION I. SCREENING FOR SUSPECT LD CASES

MRN: _____

Encounter (FIN): _____

Gender: _____

DOB: _____ Age: _____ Race/Ethnicity: _____

Type of Residence: Home LTCF Other _____

Today's date: __ / __ / __

Date of admission: __ / __ / __

Abstractors initials: _____

Did any of the following develop ≥ 48 hours of admission (do not count if present on admission)?**1. Pneumonia symptoms? (Cough, shortness of breath)** Yes No (if yes, then continue to Section II)**2. Abnormal CXR / CT suggestive of pneumonia/infiltrate?** Yes No (if yes, then continue to section II)**3. Was another etiology identified (other than Legionella)?** Yes No (if yes, then stop)

Case ID# _____

SECTION II. TYPE OF CASE

Information Source (check all that apply):

- hospital chart
- other (if other specify) _____

1. Type of exposures to Hospital A during incubation period (*check all that apply*):

- Inpatient
- Outpatient
- Visitor
- Volunteer
- Employee

2. Case definition:

- Confirmed Case
- Suspected Case
- Possible Case
- Subclinical case

3. Case Classification:

- Definitely outbreak-associated
- Possibly outbreak-associated
- Non-outbreak associated

If non-outbreak-associated, END HERE. Otherwise, continue to next page.

SECTION III. LEGIONELLA-SPECIFIC TESTING

1. Respiratory specimen collected and processed specifically for *Legionella* culture?

____ Yes ____ No ____ Unknown

a.) If YES,

Specimen type: (e.g., expectorated sputum, BAL, etc.) _____

Collected Date: ____/____/____ Laboratory Name: _____

Results: _____

b.) If NO,

Respiratory specimen collected for any culture?

____ Yes ____ No ____ Unknown

If Yes,

Specimen type: (e.g., expectorated sputum, BAL, etc.) _____

Collected Date: ____/____/____ Laboratory: _____

Results: _____

2. Urine specimen collected for *Legionella* urine antigen testing?

____ Yes ____ No ____ Unknown

Collected Date: ____/____/____ Laboratory Name: _____

Results: _____

3. Other *Legionella* testing? _____

SECTION IV. MEDICAL HISTORY

Case ID# _____

- COPD/Emphysema/Chronic Lung Disease
- Diabetes
- Congestive Heart Failure
- History of stroke/CVA
- Chronic Renal Insufficiency (CRI/CKD) or End-Stage Renal Disease (ESRD)
- Cirrhosis / Liver Disease
- Cancer (Type: _____; Date of diagnosis __/__/__)
- Organ Transplant (Type: _____) Date of transplant: __/__/__
- Bone Marrow Transplant; Date of transplant: __/__/__
- HIV/AIDS, CD4 count: _____ Date: __/__/__
- Dementia
- Taking systemic steroid
- History of chemotherapy Date: __/__/__ (Is this 1st cycle of induction chemo? Yes No)
- History of radiation Date: __/__/__
- History of pneumonia in prior year, Date: __/__/__
- Other (_____)
- Other (_____)
- History of smoking: Yes No Unknown
If yes: Current Former Unknown
- History of alcohol abuse: Yes No Unknown
- History of other substance abuse: Yes No Unknown
Specify substance(s): _____

SECTION V. SIGNS AND SYMPTOMS

- Shortness of breath; Date of onset: __ / __ / __
- Cough; Date of onset: __ / __ / __
- Fever >100.5°F; Date of onset: __ / __ / __
- Diarrhea (3 stools/24h); Date of onset: __ / __ / __
- Nausea or Vomiting; Date of onset: __ / __ / __
- Confusion (altered mental status); Date of onset: __ / __ / __
- Other (_____); Date of onset: __ / __ / __
- Other (_____); Date of onset: __ / __ / __

BEST SYMPTOM ONSET DATE: __ / __ / __

(If the patient did not have prior respiratory symptoms, choose, the onset date of cough or shortness of breath, whichever occurs first. Otherwise, use the earliest date when other symptoms suggestive of Legionella infection began.)

SECTION VI. RADIOGRAPHIC FINDINGS

Document any radiographic findings 14 days after onset of symptoms above. If multiple chest images are available, report the first for which evidence of pneumonia is noted.

Chest X-ray

If Yes, when and what were the findings?

Date: ____/____/____

- Normal Abnormal

Result:

- New Infiltrate Old / Unchanged Infiltrate Indeterminate Consolidation
 No infiltrate Not available / Unknown

Findings (impression): _____

CT Scan

If Yes, when and what were the findings?

Date: ____/____/____

- Normal Abnormal

Result:

- New Infiltrate Old / Unchanged Infiltrate Indeterminate Consolidation
 No infiltrate Not available / Unknown

Findings (impression): _____

Case ID# _____

SECTION VII. VITAL SIGNS

Highest O2 demand (FiO2): _____ Date (earliest): _____

Pulse ox (lowest recorded): _____ Date: _____

Tmax: _____ Date _____

SECTION VIII. LABORATORY VALUES

<u>TEST</u>	<u>Result</u>	<u>Date</u>
WBC (lowest)		___ / ___ / ___
% Neutrophils		___ / ___ / ___
% Lymphocytes		___ / ___ / ___
WBC (highest)		___ / ___ / ___
Hemoglobin (lowest)		___ / ___ / ___
Platelets (lowest)		___ / ___ / ___
Na (lowest)		___ / ___ / ___
Cr (highest)		___ / ___ / ___
Required dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
AST (highest)		___ / ___ / ___
ALT (highest)		___ / ___ / ___
Total bilirubin (highest)		___ / ___ / ___
Ferritin (highest)		___ / ___ / ___
CRP (highest)		___ / ___ / ___
ESR (highest)		___ / ___ / ___

SECTION IX. INVASIVE PROCEDURES

Document procedures done 14 days prior to the onset of symptoms above

<u>Procedure name</u>	<u>Date</u>
<input type="checkbox"/> NG/OG tube placement	___ / ___ / ___
<input type="checkbox"/> ET/OT/Other Intubation	___ / ___ / ___
<input type="checkbox"/> Lumbar puncture	___ / ___ / ___
<input type="checkbox"/> Thoracentesis	___ / ___ / ___
<input type="checkbox"/> Paracentesis	___ / ___ / ___
<input type="checkbox"/> Bronchoscopy	___ / ___ / ___
<input type="checkbox"/> Central line placement	___ / ___ / ___
<input type="checkbox"/> Arterial line placement	___ / ___ / ___
<input type="checkbox"/> Other _____	___ / ___ / ___
<input type="checkbox"/> Other _____	___ / ___ / ___

SECTION X. ANTIBIOTICS / IMMUNOSUPPRESSION REGIMENS					
Antibiotic / immunosuppressive therapy	Dose	Route	Start Date	End Date	Check if continued as outpatient
<input type="checkbox"/> Levofloxacin (Levoquin)					
<input type="checkbox"/> Moxifloxacin					
<input type="checkbox"/> Ciprofloxacin (Cipro)					
<input type="checkbox"/> Azithromycin (Zithromax)					
<input type="checkbox"/> Erythromycin					
<input type="checkbox"/> Rifampin					
<input type="checkbox"/> Rifapentine					
<input type="checkbox"/> Linezolid					
<input type="checkbox"/> Tetracycline					
<input type="checkbox"/> Doxycycline					
<input type="checkbox"/> Quinupristin/dalfopristin (Synercid)					
<input type="checkbox"/> Chemotherapy regimen (specify): _____					
<input type="checkbox"/> Radiation therapy (specify): _____					
<input type="checkbox"/> Systemic steroids (specify): _____					
Other (specify): _____					
Other (specify): _____					
Other (specify): _____					
Other (specify): _____					

SECTION XI. CLINICAL OUTCOMES

ICU Stay

a.) If ICU stay,

a. Number of days in ICU: _____ (count days where any time was spent in ICU)

DISPOSITION:

Still Hospitalized

Transferred to another facility (list: _____)

Discharged Home

Unknown

Deceased

b.) If deceased,

a. Date of death: _____ (mm/dd/yyyy)

b. Was a post-mortem examination performed? ___ Yes ___ No ___ Unknown

i. If yes, are tissue specimens available? ___ Yes ___ No ___ Unknown

DISCHARGE DIAGNOSIS

Legionellosis

Pneumonia

If yes, Etiology: _____ Lab Test(s): _____

Other Dx: _____

June 11, 2014

Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

**Hypothesis Generating Questionnaire
Gastroenteritis**

**Outbreak of Diarrheal Illness in American Samoa:
Hypothesis Generating Questionnaire for Gastroenteritis Complaints**

Hi! My name is_____. We are working with the Health department to try and figure out what caused the outbreak of diarrhea. Could we please ask you a few questions? Your answers will help prevent diarrhea in the future.

Your answers will be completely confidential. That means we will not share your personal information with anybody else.

Thank you!!!

1) INTERVIEWER INFORMATION:

Interviewer name:_____

Date:_____

2) DEMOGRAPHIC INFORMATION:

Patient name:_____

Name (if not the patient):_____

Relationship to child (if patient is <18 years of age):_____

Sex: M F

DOB:_____

Nationality:

- American Samoan
- Western Samoan
- Other Pacific Islander
- Asian
- White, non-Hispanic
- Black, non-Hispanic
- Unknown

Name of Village:_____

Number of people in household:

Number of adults:_____

Number of children:_____

Place of work: _____

3) CLINICAL SYMPTOMS:

According to our records, you came to the Emergency room for diarrhea on (DATE). Please think back to the week before you got sick.

When did you first get sick (mm/dd/yyyy)? _____

On what day did diarrhea begin (mm /dd /yyyy)? _____

For how many days did you experience diarrhea? : _____

When at its worst, what was the total number of episodes of diarrhea you experienced in a 24 hour period?

- 1-3 per day
- 4-6 per day
- 5-10 per day
- 10+ per day

What symptoms did you have? : *Circle all that apply.*

- Fever
- Vomiting
- Poor feeding
- Irritable
- Bloody diarrhea
- Non-bloody diarrhea
- Watery diarrhea
- Fatigue/Weakness
- Chills
- Headache
- Abdominal cramps
- Nausea
- Bodyaches

What was the first place you went to seek treatment?

- Emergency room
- Local clinic
- Village healer
- Other: _____

Did you take any medications for the diarrhea?

Over the counter: Yes No /Name: _____

From the hospital: Yes No /Name: _____

Do you use any at-home remedies for diarrhea? Yes No /Name: _____

Did you hear about diarrhea from family/friends recently? Yes No

Did you hear about diarrhea from on TV/in the newspaper recently? Yes No

How long after you first got sick did you seek medical treatment?

- Less than 1 day
- 1 – 2 days
- 3 – 4 days
- 5 – 6 days
- 7 days or more

What prompted you to go to the emergency room? *Circle all that apply.*

- Diarrhea
- Dehydration
- Fever
- Stomach / gut pain
- Unable to eat
- To get medicine
- Worried about ameba
- Friend or family member suggested going
- Other: _____

4) TRAVEL / EVENT EXPOSURES:

Did you attend flag day? Yes No

In the week before illness, did you travel anywhere outside the village? Yes No

If yes, where?

Other village(s): (Village name(s): _____

Off-island (Name of location): _____

In the week before illness, did you have contact with anyone who traveled:

Outside the village: Yes No

Off-island: Yes No

In the week before illness, were you exposed to a school or child-care facility? Yes

In the week before illness, were you exposed to any flies? Yes No

Is your home screened? Yes No

Do you have a refrigerator? Yes No

In the week before illness, did you attend any special events where food was served or catered (weddings, community meetings, church events, etc.)? Yes No

If yes:

#1 Type of event: _____

#1 Was there a sink with soap and water to wash your hands? Yes No

#2 Type of event: _____

#2 Was there a sink with soap and water to wash your hands? Yes No

In the week before illness, did you go swimming or have other recreational water exposures (fishing, etc.)? Yes No

If yes, please describe:

5) HOUSEHOLD WATER EXPOSURES:

What is the water supply source for your home or residence? *Circle all that apply.*

- ASPA water
- Village water
- Rain water
- Vending machines
- Bottled water
- Other: _____

If multiple sources, what source is usually used for each?

Drinking: _____

Cooking: _____

Bathing: _____

Washing clothing: _____

Cleaning: _____ Hand

washing: _____

Where do you typically wash your hands at home?

When do you typically wash your hands at home?

When you don't wash your hands at home, what are some reasons why?

Does the household usually boil or filter water before use for cooking?

- Boiling
- Filtering
- No treatment

Does the household usually boil or filter water before use for drinking?

- Boiling
- Filtering
- No treatment

6) SEWAGE EXPOSURES:

What type of sewage disposal does your house have?

- ASPA sewage
- Septic Tank
- Cesspool
- Nothing
- Other : _____

41. How do you dispose of trash?

- ASPA
- Self-disposal
- Other: _____

IF ASPA:

How many days per week is trash collected by ASPA?

_____ days per week

IF SELF DISPOSAL:

How many days per week is trash taken outside the house?

_____ days per week

How many days per week is trash taken off the property?

_____ days per week

Where do you take the trash to: _____

7) FOOD EXPOSURES:

What do you eat on a typical day?

Breakfast

What do you eat?

Where do you eat? _____

Lunch

What do you eat?

Where do you eat? _____

Dinner

What do you eat?

Where do you eat? _____

Snacks

What do you eat?

Where do you eat? _____

Drinks

What do you drink?

Where do you usually shop for groceries?

What restaurants do you usually go to?

8) ILL CONTACTS:

Do you know anyone else who is ill? Yes No

#1 Relation to you: _____

#1 Does this person live with you?: _____

#1 Village: _____

#2 Relation to you: _____

#2 Does this person live with you?: _____

#2 Village: _____

#3 Relation to you: _____

#3 Does this person live with you?: _____

#3 Village: _____

#4 Relation to you: _____

#4 Does this person live with you?: _____

#4 Village: _____

#5 Relation to you: _____

#5 Does this person live with you?: _____

#5 Village: _____

9) PERSONAL OPINION

How do you think you got sick?

Is there anything else you would like to share with us, relating to the diarrhea outbreak?

THANK YOU SO MUCH FOR YOUR TIME!!!
We truly appreciate your talking to us today.

Household Line Listing Measles

Public reporting burden of this collection of information is estimated to average 55 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 (0920-1011)

Measles Case ID # _____ Case-Patient's Name _____

List Dates of HH Visits ___/___/___ ___/___/___ ___/___/___ Household Location: Municipality _____ Village _____

Number of Rooms in the House ____ Number of Persons Living in the House ____

HH No.	First Name Last Name	Sex	Date of Birth	Age (y, m)	Mother's First Name (If age 39 or less)	Fever and rash in the last 2 months (May/June)?	Had measles before this year?	MMR Doses	MMR Dates	Doses obtained (check one)	Lived/slept at least one night in the HH from 3 days prior and 3 days after rash onset of 1 st case?
1			___/___/___			Yes Date of onset ___/___/___ No	Yes No	0___ 1___ 2___ 3___	___/___/___ ___/___/___ ___/___/___	___ by history ___ from record	Yes No
2			___/___/___			Yes Date of onset ___/___/___ No	Yes No	0___ 1___ 2___ 3___	___/___/___ ___/___/___ ___/___/___	___ by history ___ from record	Yes No
3			___/___/___			Yes Date of onset ___/___/___ No	Yes No	0___ 1___ 2___ 3___	___/___/___ ___/___/___ ___/___/___	___ by history ___ from record	Yes No
4			___/___/___			Yes Date of onset ___/___/___ No	Yes No	0___ 1___ 2___ 3___	___/___/___ ___/___/___ ___/___/___	___ by history ___ from record	Yes No
5			___/___/___			Yes Date of onset ___/___/___ No	Yes No	0___ 1___ 2___ 3___	___/___/___ ___/___/___ ___/___/___	___ by history ___ from record	Yes No
6			___/___/___			Yes Date of onset ___/___/___ No	Yes No	0___ 1___ 2___ 3___	___/___/___ ___/___/___ ___/___/___	___ by history ___ from record	Yes No
7			___/___/___			Yes Date of onset ___/___/___ No	Yes No	0___ 1___ 2___ 3___	___/___/___ ___/___/___ ___/___/___	___ by history ___ from record	Yes No
8			___/___/___			Yes Date of onset ___/___/___ No	Yes No	0___ 1___ 2___ 3___	___/___/___ ___/___/___ ___/___/___	___ by history ___ from record	Yes No

HH No.	First Name Last Name	Sex	Date of Birth	Age (y, m)	Mother's First Name (If age 39 or less)	Fever and rash in the last 2 months (May/June)?	Had measles before this year?	MMR Doses	MMR Dates	Doses obtained (check one)	Lived/slept at least one night in the HH from 3 days prior and 3 days after rash onset of 1 st case?
9			__/__/__			Yes Date of onset __/__/__ No	Yes No	0__ 1__ 2__ 3__	__/__/__ __/__/__ __/__/__	_ by history _ from record	Yes No
10			__/__/__			Yes Date of onset __/__/__ No	Yes No	0__ 1__ 2__ 3__	__/__/__ __/__/__ __/__/__	_ by history _ from record	Yes No
11			__/__/__			Yes Date of onset __/__/__ No	Yes No	0__ 1__ 2__ 3__	__/__/__ __/__/__ __/__/__	_ by history _ from record	Yes No
12			__/__/__			Yes Date of onset __/__/__ No	Yes No	0__ 1__ 2__ 3__	__/__/__ __/__/__ __/__/__	_ by history _ from record	Yes No
13			__/__/__			Yes Date of onset __/__/__ No	Yes No	0__ 1__ 2__ 3__	__/__/__ __/__/__ __/__/__	_ by history _ from record	Yes No
14			__/__/__			Yes Date of onset __/__/__ No	Yes No	0__ 1__ 2__ 3__	__/__/__ __/__/__ __/__/__	_ by history _ from record	Yes No
15			__/__/__			Yes Date of onset __/__/__ No	Yes No	0__ 1__ 2__ 3__	__/__/__ __/__/__ __/__/__	_ by history _ from record	Yes No
16			__/__/__			Yes Date of onset __/__/__ No	Yes No	0__ 1__ 2__ 3__	__/__/__ __/__/__ __/__/__	_ by history _ from record	Yes No
17			__/__/__			Yes Date of onset __/__/__ No	Yes No	0__ 1__ 2__ 3__	__/__/__ __/__/__ __/__/__	_ by history _ from record	Yes No

HH No.	First Name Last Name	Sex	Date of Birth	Age (y, m)	Mother's First Name (If age 39 or less)	Fever and rash in the last 2 months (May/June)?	Had measles before this year?	MMR Doses	MMR Dates	Doses obtained (check one)	Lived/slept at least one night in the HH from 3 days prior and 3 days after rash onset of 1 st case?
18			____/____/____			Yes Date of onset ____/____/____ No	Yes No	0____ 1____ 2____ 3____	____/____/____ ____/____/____ ____/____/____	____ by history ____ from record	Yes No

Dengue and chikungunya report form

Public reporting burden of this collection of information is estimated to average 5 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 (0920-1011)



DENGUE & CHIKUNGUNYA REPORT FORM

U.S. Virgin Islands Department of Health
Charles Harwood Complex, 3500 Estate Richmond
Christiansted, St. Croix, USVI 00820-4370
Tel. (340) 773-1311 x3241, Fax (340) 718-1508

SUSPECTED CHIK? Yes No

Today's date: _____
Day/Month/Year

Case number	Specimen #	Days post onset (DPO)	Type	Date Received	Specimen #	Days post onset (DPO)	Type	Date Received
<input type="text"/>	S1				S3			
SAN ID	GCODE	S2			S4			

Please read and complete ALL sections

Patient Data Hospitalized due to this illness: No Yes → Hospital Name: _____ Record Number: _____

Name of Patient: Last Name _____ First Name _____ Middle Name or Initial _____
 If patient is a minor, name of father or primary caregiver: Last Name _____ First Name _____ Middle Name or Initial _____

Fatal: Yes No Unk
 Mental status changes: Yes No Unk

Home (Physical) Address

Home address here ↩

City: _____ Zip code: _____ - _____
 Tel: _____ Other Tel: _____
 Residence is close to: _____
 Work address: _____

Physician who referred this case

Name of Healthcare Provider: _____
 Tel: _____ Fax: _____ Email: _____
 Do you want to receive laboratory results via Fax or Email? _____

Patient's Demographic Information

Date of Birth: _____ Age: _____ months Sex: M F
 or Age: _____ years Pregnant: Y N UNK
 Day/Month/Year Weeks pregnant (gestation): _____

Who filled out this form?

Name (complete) _____
 Relationship with patient: _____
 Tel: _____ Fax: _____ Email: _____

Must have the following information for sample processing

Date of first symptom: _____ Day/Month/Year
 Date specimen taken: _____
 First sample _____
 Second sample _____

How long have you lived in this city? _____ Country of birth _____
 During the 14 days before onset of illness, did you TRAVEL to other cities or countries?
 Yes, another country Yes, another city No Unknown
 WHERE did you TRAVEL? _____
 Are there any sick contacts in your household?
 Yes No

PLEASE indicate below the signs and symptoms that the patient had at the time of illness

	Yes	No	Unk						Yes	No	Unk		
Fever lasting 2-7 days.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Evidence of capillary leak	Lowest hematocrit (%)				Warning signs	Persistent vomiting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever (>38°C/101°F).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Highest hematocrit (%)					Abdominal pain/Tenderness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Platelets ≤100,000/mm ³	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest serum albumin					Mucosal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Platelet count: _____				Lowest serum protein					Lethargy, restlessness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Any hemorrhagic manifestation				Lowest blood pressure (SBP/DBP) _____/_____					Liver enlargement >2cm.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Petechiae.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest pulse pressure (systolic - diastolic) _____					Pleural or abdominal effusion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Purpura/Ecchymosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowest white blood cell count (WBC) _____					Additional symptoms	Diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomit with blood.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Symptoms	Rapid, weak pulse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood in stool.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pallor or cool skin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Conjunctivitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nasal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Nasal congestion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding gums.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rash.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Sore throat.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood in urine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vaginal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Convulsion or coma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Positive urinalysis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Body (muscle/bone) pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Nausea and vomiting (occasional).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(over 5 RBC/hpf or positive for blood)				Joint pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis (Swollen joints).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tourniquet test <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done				Anorexia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Missed school/work due to this illness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
									Unable to walk during this illness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Suspected Chikungunya Case Questionnaire

August 16, 2014

Interviewer: _____ Date of Interview: ___/___/_____

Name of person/parent giving consent: _____ Refused Interview

If case-patient is not available, ask for an alternate contact number or time to call back to speak with case patient. Alternate number _____ Alternate day/time _____

1.) We have your age (your child's age) as _____, is this correct? *[If no]* What is the correct age? _____

a. *[For parents <17 year old child]* Can I ask what is your age and sex?

Age in years _____ Sex: Male Female

2.) Per our records, a sample was taken for chikungunya testing on ___/___/2014, does this sound correct?

Yes No

[If this is not correct] Can you recall which date the sample was drawn? ___/___/2014

3.) Besides yourself (or your child), has anyone else in your household had similar symptoms?

Yes *(go to question 4)*

No *(go to question 5)*

Don't know *(go to question 5)*

4.) How many of these household members with similar symptoms sought medical care? _____

5.) How long did the initial joint pain last when you were tested for Chikungunya? _____ days after symptoms started.

6.) Do you have any joint pain (i.e., pain in your wrists, ankles, hands or feet) or joint swelling today that you think might be related to your recent illness?

Yes *(go to question 8)*

No *(go to question 7)*

Don't know *(go to question 7)*

7.) Have you (or your child) had any joint pain or swelling in the last week that you think might be related to your recent illness?

Yes *(go to question 8)*

No *(go to question 9)*

Don't know

8.) How often do you (your child) experience joint pain or swelling that you think might be related to your recent illness?

Daily

Two to three times per week

Once per week

Less than once per week

Don't know

9.) What is your current employment status?

- Working (go to question 10)
- Retired (go to question 13)
- Not Working (go to question 13)
- Child (go to question 15)
- Refused

10.) In the time since you have visited the doctor for suspected chikungunya, have you missed time from work because of your illness?

- Yes (go to question 11)
- No (go to question 16)

11.) Have you (your parent) returned to work?

- Yes (go to question 12)
- No (go to question 16)

12.) How many days of work did you miss? _____ (go to question 16)

13.) In the time since you visited the doctor for suspected chikungunya, have you been unable to do your normal chores and activities?

- Yes (go to question 14)
- No (go to question 16)

14.) How many days of chores/activities have you missed? _____ (go to question 16)

15.) Have you (or has your parent) had to miss work to care for your sick child (or you)?

- Yes (go to question 11)
- No (go to question 16)

16.) Were you been hospitalized due to your illness for which you were tested for chikungunya?

- Yes (go to question 17)
- No (go to question 18)

17.) How many days were you hospitalized? _____

18.) Did you seek additional medical attention following the date your sample was drawn for suspected chikungunya?

- Yes (go to question 19)
- No (go to question 20)

19.) How many times did you seek medical attention? _____ healthcare visits

20.) Do you have a history of chronic joint pain prior to being diagnosed with chikungunya?

- Yes
- No

Thank you for answering our additional question. The information you have provide will let us learn more about chikungunya and how the disease is affecting you and other people in your community.

Would you be willing for the health department to contact you again related to your illness?

- Yes
- No

Finally, do you have any questions for me?

CHIKUNGUNYA INVESTIGATION — HOUSEHOLD INTERVIEW FORM

Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

TEAM #: _____ DATE: ____/____/____ Household ID (e.g., SJ-1-A): _____-_____-_____

GPS Coordinates: _____, _____, _____ SANID of lab-positive case: _____

How many people live in this house? _____ people

List all members of household below put yourself first.

Head of household contact number to facilitate return of test results: _____

	Name (First, Paternal, Maternal)	Age	Gender	Participate?	Place sticker here
1			M / F	Yes / No	
2			M / F	Yes / No	
3			M / F	Yes / No	
4			M / F	Yes / No	
5			M / F	Yes / No	
6			M / F	Yes / No	
7			M / F	Yes / No	
8			M / F	Yes / No	

Public reporting burden of this collection of information is estimated to average 15 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 (0920-1011)

CHIKUNGUNYA INVESTIGATION — HOUSEHOLD INTERVIEW FORM

Household Characteristics

Housing type (check only one): One story house Two story house Apartment/condo building
 Public housing Temporary shelter

Has anyone in your immediate household traveled outside of Puerto Rico in the past 3 months? Yes No

Has anyone in your household been sick in the past 3 months? Yes No

Does your home have screened windows and doors? All rooms Some rooms No

Do you regularly use air conditioning in your home? Yes, in all rooms Yes, but only in some rooms No

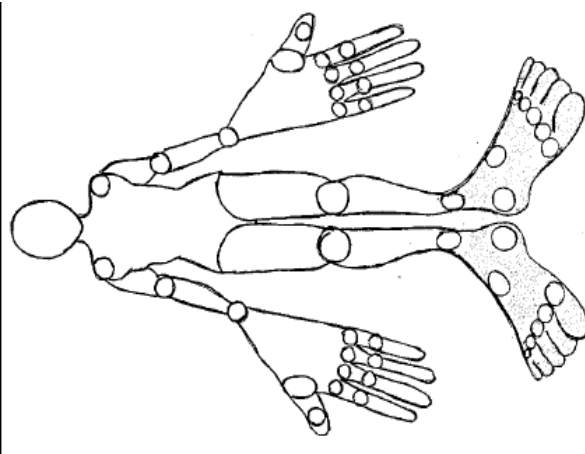
Do you regularly leave your doors or windows open? Daytime only Night-time only Always Never

Do you use mosquito coils in your house or patio? Yes No

Do you use citronela in your house or patio to keep mosquitoes away? Yes No

Notes:

7b-1. If you had joint pain, indicate the locations where you had the pain



7c. How long did this illness last? _____ days

7d. Did you go to the doctor because of this illness? Yes No

7d-1. If yes, Name of hospital/clinic: _____

7d-2. What was the diagnosis? Chikungunya Dengue

Viral syndrome I don't know Other: _____

7d-3. Were you hospitalized for this illness? Yes No

7d-3a. If yes, Hospital Name: _____

7d-3b. Days in the hospital: _____ days

8. Have you used mosquito repellent in the past month? Daily Weekly Never

9. Have you slept under a bednet in the past month? Yes No

10. Have you traveled outside of Puerto Rico in the past 3 months? Yes No

10a. If yes, specify where and date of return to Puerto Rico for the most recent trip:

United States (excluding USVI) Dominican Republic Caribbean cruise

Other: _____

Date of return to PR (MM/DD/YYYY): _____/_____/_____

NOTES:



Estado Libre Asociado de Puerto Rico
Departamento de Salud

SISTEMA CENTINELA DE VIGILANCIA DE CHIKUNGUNYA (CHIKSS) REPORTE DE CASO

Form Approved
OMB No. 0920-1011
Exp.: 3/31/2014

REVISADO:
(iniciales)

Fecha de hoy: ___/___/___
Dia Mes Año

FIEBRE + POLIARTRALGIA + NO TOS

SOLAMENTE PARA USO DEL LABORATORIO

Número de caso	Espécimen #	Días después 1er síntoma	Tipo	Fecha recibido	Espécimen #	Días después 1er síntoma	Tipo	Fecha recibido
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
SAN ID	GCODE	S1			S3			
<input type="text"/>	<input type="text"/>	S2			S4			

Favor de leer y completar TODAS las secciones

Datos del paciente

Se hospitalizó por esta enfermedad: No Sí → Nombre del hospital: _____ Número de expediente: _____

Nombre del Paciente: _____ Apellido paterno Apellido materno Nombre Segundo nombre / inicial	Falleció: <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe
Si el paciente es un menor, nombre del padre o encargado: _____ Apellido paterno Apellido materno Nombre Segundo nombre / inicial	Cambios en estado mental: <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe

Dirección residencial completa (Física)

Médico o proveedor que ordenó la prueba de chikungunya

Dirección de la casa aquí

Municipio: _____ Código postal: _____ - _____

Tel.: _____ Otro Tel.: _____

Vive cerca de: _____

Nombre y dirección del trabajo: _____

Nombre: _____

Hospital:

Bella Vista HIMA Fajardo CDT San José

Buen Samaritano San Jorge Children's

HIMA Caguas Susoni

Información demográfica del paciente

¿Quién llenó este formulario?

Fecha nacimiento: _____ Edad: _____ meses Sexo: M F

_____/_____/_____ ó Edad: _____ años ¿Encinta?: Sí No NS

Dia Mes Año Semanas de gestación

Doctor(a) Enfermero(a) OTRO _____

Datos indispensables para procesar las muestras

Datos adicionales del paciente

Fecha del primer síntoma: _____
Dia Mes Año

Fecha de toma de muestra: _____
Dia Mes Año

¿Cuántos años ha vivido en este municipio? _____

¿En qué país nació? _____

¿Durante los 14 días antes de enfermar, ¿VIAJÓ a otro país o pueblo?
 Sí, otro país Sí, otro pueblo No No sabe

¿A dónde viajó? _____

¿Desde que se enfermó, faltó a la escuela/trabajo?
 SI NO NO APLICA

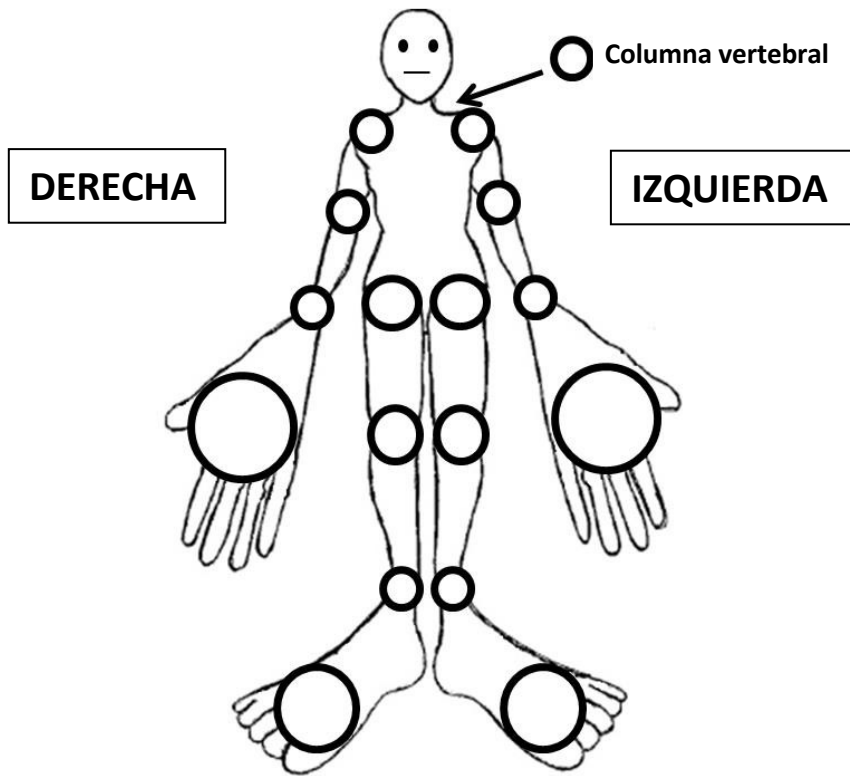
POR FAVOR indique todos los signos y síntomas del paciente

<p>Fiebre durante 2 – 7 días <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Fiebre (>38°C/101°F)..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Alguna manifestación hemorrágica</p> <p>Petequias..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Equimosis o Cardenales..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Vómito con sangre..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Sangre en la excreta..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Hemorragia nasal..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Hemorragia de las encías..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Sangre en la orina..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Hemorragia vaginal..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Urianálisis positivo..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe (sobre 5 RBC/hpf o positivo para sangre)</p>	<p>Medidas Clínicas</p> <p>Presión arterial (SBP/DBP) : _____/_____</p> <p>Hematocrito (%): _____</p> <p>Conteo de glóbulos blancos (WBC): _____ Conteo de plaquetas: _____</p> <p>Síntomas</p> <p>Pulso acelerado y débil..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Palidez o piel fría <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Erupción de la piel..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Dolor de cabeza..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Dolor en los ojos..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Dolor en el cuerpo <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Dolor de coyunturas <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Anorexia..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p>	<p>Señales de advertencia</p> <p>Vómito persistente <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Dolor abdominal/sensibilidad <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Sangrado de las mucosas <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Letargia/inquietud..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Agrandamiento del hígado > 2cm..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Efusión pleural o abdominal..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Síntomas adicionales</p> <p>Diarrea..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Tos..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Conjuntivitis..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Congestión nasal..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Dolor de garganta..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Ictericia..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Convulsión o coma..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Náusea y vómito (ocasional)..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>Artritis (coyunturas hinchadas)..... <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p> <p>No puede caminar <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe</p>
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CONTINÚE AL DORSO!!

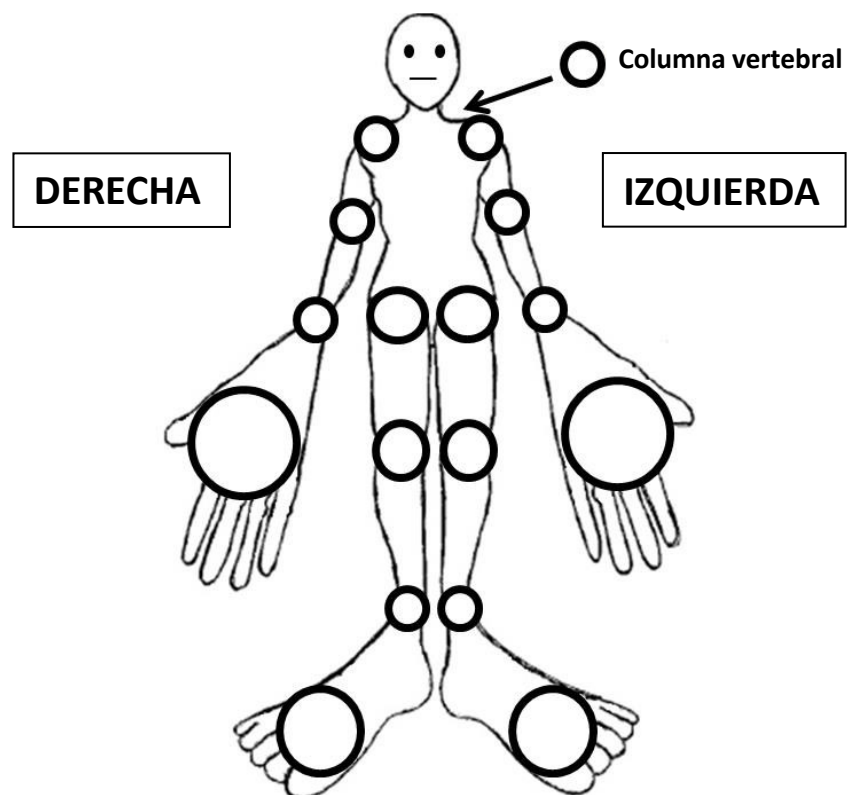
Este formulario está autorizado por la Ley 42 USC 241 del Servicio de Salud Pública. Contestar este formulario es voluntario, pero, se necesita la cooperación del paciente para el estudio y control de enfermedades. Contestar las preguntas toma aproximadamente 15 minutos por formulario. Envíe sus comentarios y sugerencias sobre el tiempo que toma llenar el formulario o sobre cualquier otro aspecto de la recopilación de información a: CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).

Los círculos a continuación representan las coyunturas en el cuerpo humano, marque con una "X" las áreas donde el paciente tiene **DOLOR**



ESPACIO PARA ETIQUETA DEL LABORATORIO

Los círculos a continuación representan las coyunturas en el cuerpo humano, marque con una "X" las áreas donde el paciente tiene **LAS COYUNTURAS ROJAS E HINCHADAS**



Appendix 1:

**VIRAL HEMORRHAGIC FEVER
CASE INVESTIGATION FORM**

VIRAL HEMORRHAGIC FEVER CASE INVESTIGATION FORM

Outbreak
Case ID:

Health
Facility
Case ID:

Date of Case Report: ___/___/___ (D, M, Yr)

Section 1. Patient Information

Patient's Surname: _____ Other Names: _____ Age: _____ Years Months
Gender: Male Female Phone Number of Patient/Family Member: _____ Owner of Phone: _____

Status of Patient at Time of This Case Report: Alive Dead *If dead, Date of Death: ___/___/___ (D, M, Yr)*

Permanent Residence:

Head of Household: _____ Village/Town: _____ Parish: _____
Country of Residence: _____ District: _____ Sub-County: _____

Occupation:

Farmer Butcher Hunter/trader of game meat Miner Religious leader Housewife Pupil/student Child
 Businessman/woman; type of business: _____ Transporter; type of transport: _____
 Healthcare worker; position: _____ healthcare facility: _____ Traditional/spiritual healer
 Other; please specify occupation: _____

Location Where Patient Became Ill:

Village/Town: _____ District: _____ Sub-County: _____
GPS Coordinates at House: latitude: _____ longitude: _____
If different from permanent residence, Dates residing at this location: ___/___/___ - ___/___/___ (D, M, Yr)

Section 2. Clinical Signs and Symptoms

Date of Initial Symptom Onset: ___/___/___ (D, M, Yr)

Please tick an answer for **ALL** symptoms indicating if they occurred during **this illness** between symptom onset and case detection:

Fever Yes No Unk

If yes, Temp: ___° C Source: Axillary Oral Rectal

Vomiting/nausea Yes No Unk

Diarrhea Yes No Unk

Intense fatigue/general weakness Yes No Unk

Anorexia/loss of appetite Yes No Unk

Abdominal pain Yes No Unk

Chest pain Yes No Unk

Muscle pain Yes No Unk

Joint pain Yes No Unk

Headache Yes No Unk

Cough Yes No Unk

Difficulty breathing Yes No Unk

Difficulty swallowing Yes No Unk

Sore throat Yes No Unk

Jaundice (yellow eyes/gums/skin) Yes No Unk

Conjunctivitis (red eyes) Yes No Unk

Skin rash Yes No Unk

Hiccups Yes No Unk

Pain behind eyes/sensitive to light Yes No Unk

Coma/unconscious Yes No Unk

Confused or disoriented Yes No Unk

Unexplained bleeding from any site Yes No Unk

If Yes:

Bleeding of the gums Yes No Unk

Bleeding from injection site Yes No Unk

Nose bleed (epistaxis) Yes No Unk

Bloody or black stools (melena) Yes No Unk

Fresh/red blood in vomit (hematemesis) Yes No Unk

Digested blood/"coffee grounds" in vomit Yes No Unk

Coughing up blood (hemoptysis) Yes No Unk

Bleeding from vagina,
other than menstruation Yes No Unk

Bruising of the skin
(petechiae/ecchymosis) Yes No Unk

Blood in urine (hematuria) Yes No Unk

Other hemorrhagic symptoms Yes No Unk

If yes, please specify: _____

Other non-hemorrhagic clinical symptoms: Yes No Unk

If yes, please specify: _____

Section 3. Hospitalization Information

At the time of this case report, is the patient hospitalized or currently being admitted to the hospital? Yes No

If yes, Date of Hospital Admission: ___/___/___ (D, M, Yr) Health Facility Name: _____

Village/Town: _____ District: _____ Sub-County: _____

Is the patient in isolation or currently being placed there? Yes No *If yes, date of isolation: ___/___/___ (D, M, Yr)*

Was the patient hospitalized or did he/she visit a health clinic previously **for this illness**? Yes No Unk

If yes, please complete a line of information for each previous hospitalization:

Dates of Hospitalization	Health Facility Name	Village	District	Was the patient isolated?
___/___/___ - ___/___/___ (D, M, Yr)				<input type="checkbox"/> Yes <input type="checkbox"/> No
___/___/___ - ___/___/___ (D, M, Yr)				<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 4. Epidemiological Risk Factors and Exposures

IN THE PAST ONE(1) MONTH PRIOR TO SYMPTOM ONSET:

1. Did the patient have contact with a known or suspect case, or with any sick person **before** becoming ill? Yes No Unk
If yes, please complete one line of information for each sick source case:

Name of Source Case	Relation to Patient	Dates of Exposure (D, M, Yr)	Village	District	Was the person dead or alive ?	Contact Types**
		___/___/___ - ___/___/___			<input type="checkbox"/> Alive <input type="checkbox"/> Dead, date of death: ___/___/___ (D, M, Y)	
		___/___/___ - ___/___/___			<input type="checkbox"/> Alive <input type="checkbox"/> Dead, date of death: ___/___/___ (D, M, Y)	
		___/___/___ - ___/___/___			<input type="checkbox"/> Alive <input type="checkbox"/> Dead, date of death: ___/___/___ (D, M, Y)	

****Contact Types:**
(list all that apply)

- 1 – Touched the body fluids of the case (blood, vomit, saliva, urine, feces)
- 2 – Had direct physical contact with the body of the case (alive or dead)
- 3 – Touched or shared the linens, clothes, or dishes/eating utensils of the case
- 4 – Slept, ate, or spent time in the same household or room as the case

2. Did the patient attend a funeral **before** becoming ill? Yes No Unk
If yes, please complete one line of information for each funeral attended:

Name of Deceased Person	Relation to Patient	Dates of Funeral Attendance (D, M, Yr)	Village	District	Did the patient participate (carry or touch the body)?
		___/___/___ - ___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No
		___/___/___ - ___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Did the patient travel outside their home or village/town **before** becoming ill? Yes No Unk
If yes, Village: _____ District: _____ Date(s): ___/___/___ - ___/___/___ (D, M, Yr)

4. Was the patient hospitalized or did he/she go to a clinic or visit anyone in the hospital **before** this illness? Yes No Unk
If yes, Patient Visited: _____ Date(s): ___/___/___ - ___/___/___ (D, M, Yr)
Health Facility Name: _____ Village: _____ District: _____

5. Did the patient consult a traditional/spiritual healer **before** becoming ill? Yes No Unk
If yes, Name of Healer: _____ Village: _____ District: _____ Date: ___/___/___ (D, M, Yr)

6. Did the patient have direct contact (hunt, touch, eat) with animals or uncooked meat **before** becoming ill? Yes No Unk
If yes, please tick all that apply:

<p>Animal:</p> <p><input type="checkbox"/> Bats or bat feces/urine</p> <p><input type="checkbox"/> Primates (monkeys)</p> <p><input type="checkbox"/> Rodents or rodent feces/urine</p> <p><input type="checkbox"/> Pigs</p> <p><input type="checkbox"/> Chickens or wild birds</p> <p><input type="checkbox"/> Cows, goats, or sheep</p> <p><input type="checkbox"/> Other; specify _____</p>	<p>Status (check one only):</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p>
---	--

7. Did the patient get bitten by a tick in the past 2 weeks? Yes No Unk

Section 5. Clinical Specimens and Laboratory Testing

- Specimen/shipping instructions:**
- Label sample with patient name, date of collection, and case ID
 - Send sample **cold** with a **cold/ice pack**, and **packaged appropriately**.
 - Collect whole blood in a purple top (EDTA) tube – green or red top tubes acceptable if purple not available
 - Preferred sample volume = 4ml** (minimum sample volume = 2ml)

Has this patient had a sample submitted previously? Yes No

Sample 1:

*Do not complete
UVRI Only*

Sample Collection Date: ___/___/___ (D, M, Yr)

Sample Type:

- Whole Blood
- Post-mortem heart blood
- Skin biopsy
- Other specimen type, specify: _____

Sample 2:

*Do not complete
UVRI Only*

Sample Collection Date: ___/___/___ (D, M, Yr)

Sample Type:

- Whole Blood
- Post-mortem heart blood
- Skin biopsy
- Other specimen type, specify: _____

Section 6. Case Report Form Completed by:

Name: _____ Phone: _____ E-mail: _____

Position: _____ District: _____ Health Facility: _____

Information provided by: Patient Proxy; If proxy, Name: _____ Relation to Patient: _____

Case Name:

Outbreak Case ID:

****If the patient is deceased or has already recovered from illness, please fill out the next section.
If the patient is currently admitted to the hospital, leave the next section blank (it will be completed upon discharge)

Section 7. Patient Outcome Information

Please fill out this section at the time of patient recovery and discharge from the hospital OR at the time of patient death.

Date Outcome Information Completed: ____/____/____ (D, M, Yr)

Final Status of the Patient: Alive Dead

Did the patient have signs of unexplained bleeding at any time during their illness? Yes No Unk

If yes, please specify: _____

If the patient has recovered and been discharged from the hospital:

Name of hospital discharged from: _____ District: _____

If the patient was isolated, Date of discharge from the isolation ward: ____/____/____ (D, M, Yr)

Date of discharge from the hospital: ____/____/____ (D, M, Yr)

If the patient is dead:

Date of Death: ____/____/____ (D, M, Yr)

Place of Death: Community Hospital: _____ Other: _____

Village: _____ District: _____ Sub-County: _____

Date of Funeral/Burial: ____/____/____ (D, M, Yr) Funeral conducted by: Family/community Outbreak burial team

Place of Funeral/Burial:

Village: _____ District: _____ Sub-County: _____

Please tick an answer for ALL symptoms indicating if they occurred at any time during this illness including during hospitalization:

Fever Yes No Unk

If yes, Temp: ____° C Source: Axillary Oral Rectal

Vomiting/nausea Yes No Unk

Diarrhea Yes No Unk

Intense fatigue/general weakness Yes No Unk

Anorexia/loss of appetite Yes No Unk

Abdominal pain Yes No Unk

Chest pain Yes No Unk

Muscle pain Yes No Unk

Joint pain Yes No Unk

Headache Yes No Unk

Cough Yes No Unk

Difficulty breathing Yes No Unk

Difficulty swallowing Yes No Unk

Sore throat Yes No Unk

Jaundice (yellow eyes/gums/skin) Yes No Unk

Conjunctivitis (red eyes) Yes No Unk

Skin rash Yes No Unk

Hiccups Yes No Unk

Pain behind eyes/sensitive to light Yes No Unk

Coma/unconscious Yes No Unk

Confused or disoriented Yes No Unk

Other non-hemorrhagic clinical symptoms: Yes No Unk

If yes, please specify: _____

Appendix 2:

CONTACT TRACING FORM

Public reporting burden of this collection of information is estimated to average 3 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 (0920-1011)



UAC Respiratory Disease Cluster Case Investigation Form

Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

State: _____ Date reported to health department: ___/___/___ (MM/DD/YYYY) Date interview completed: ___/___/___ (MM/DD/YYYY)

Alien Number: _____ CDC Lab ID: _____

Demographic Information

1. Date of birth: ___/___/___ (MM/DD/YYYY)
2. Country of origin: _____ Region: _____ City/town: _____
3. Estimated travel time from country of origin to US border: _____ days weeks months
4. Ethnicity: Hispanic or Latino Not Hispanic or Latino
5. Sex: Male Female

Symptoms and Care Seeking

6. What date did symptoms associated with this illness start? ___/___/___ (MM/DD/YYYY)
7. Were symptoms present at the CBP Processing Center? Yes No Unknown
8. Were symptoms present at a CBP facility before transfer to the processing center? Yes, which facility? _____ No Unknown
9. During this illness, did the patient experience any of the following?

Symptom	Symptom Present?	Symptom	Symptom Present?
Fever (highest temp _____ °F)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
If fever present, date of onset ___/___/___ (MM/DD/YYYY)		Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Felt feverish	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
If felt feverish, date of onset ___/___/___ (MM/DD/YYYY)		Eye infection/redness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Muscle aches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other, specify	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

10. Does the patient still have symptoms?
 Yes (skip to Q.12) No Unknown (skip to Q.12)
11. When did the patient feel back to normal? ___/___/___ (MM/DD/YYYY)
12. Did the patient receive any medical care for the illness?
 Yes No (skip to Q.14) Unknown (skip to Q.14)
13. Where and on what date did the patient seek care (check all that apply)?
 CBP Processing Center **date:** ___/___/___ (MM/DD/YYYY) Shelter medical service **date:** ___/___/___ (MM/DD/YYYY)
 Urgent care **date:** ___/___/___ (MM/DD/YYYY) Emergency room **date:** ___/___/___ (MM/DD/YYYY)
 Other _____ **date:** ___/___/___ (MM/DD/YYYY) Unknown
14. Did the patient experience any other complications as a result of this illness? Yes (please describe below) No Unknown

15. Does the patient have any preexisting medical conditions (e.g. problems with heart, lung)? Yes (please describe below) No Unknown

Risk Factors

16. In the 7 days prior to illness onset, please list the locations/CPB facilities the patient has been (including international).
Location 1: Dates: ___/___/___ to ___/___/___ Country _____ State _____ City/CPB facility _____
Location 2: Dates: ___/___/___ to ___/___/___ Country _____ State _____ City/CPB facility _____
Location 3: Dates: ___/___/___ to ___/___/___ Country _____ State _____ City/CPB facility _____
17. Which dormitory was the patient in when symptomatic? _____ (dormitory 101-110)
18. Which bed number was the patient in when symptomatic? _____
19. Does the patient know anyone who had fever, respiratory symptoms like cough or sore throat, or another respiratory illness like pneumonia **in the 7 days BEFORE** the case patient's illness onset?
 Yes (**please list those ill before the case patient in the table below**) No Unknown

Contact name	Sex (M/F)	Age	Date of illness onset	Comments



UAC Respiratory Disease Cluster Case Investigation Form

20. Any additional comments or notes?

Please review the patient's medical record, patient testing results, and facility records to obtain the answers for the remainder of the form.

Clinical Course, Treatment, and Outcome

21. Date of identification by CBP: ____/____/____ (MM/DD/YYYY)
22. Date of arrival to CBP Processing Center: ____/____/____ (MM/DD/YYYY) Nogales, AZ or McAllen, TX Other: _____
23. Date of arrival to Baytown Shelter: ____/____/____ (MM/DD/YYYY)
24. Approximately how many children were in the patient's dormitory at the shelter on the date of symptom onset? _____
25. Were other persons in the same dormitory symptomatic in the 7 days prior to the illness onset in this patient?
 Yes No (skip to Q.27) Unknown (skip to Q.27)
26. How many persons were ill? _____
27. Was the patient hospitalized for the illness?
 Yes No (skip to Q.36) Unknown (skip to Q.36)
28. Date(s) of hospital admission? **First admission date:** ____/____/____ (MM/DD/YYYY) **Second admission date:** ____/____/____ (MM/DD/YYYY)
29. Was the patient admitted to an intensive care unit (ICU)?
 Yes No (skip to Q.31) Unknown (skip to Q.31)
30. Date of **ICU admission:** ____/____/____ (MM/DD/YYYY) Date of **ICU discharge:** ____/____/____ (MM/DD/YYYY)
31. Did the patient receive mechanical ventilation / have a breathing tube?
 Yes No (skip to Q.33) Unknown (skip to Q.33)
32. For how many days did the patient receive mechanical ventilation or have a breathing tube? _____ days
33. Was the patient discharged?
 Yes No (skip to Q.36) Unknown (skip to Q.36)
34. Date(s) of hospital discharge? **First discharge date:** ____/____/____ (MM/DD/YYYY) **Second discharge date:** ____/____/____ (MM/DD/YYYY)
35. Where was the patient discharged?
 NBVC Shelter Family member Permanent shelter Other _____ Unknown
36. Did the patient have a new abnormality on chest x-ray or CAT scan?
 No, x-ray or scan was normal Yes, x-ray or scan detected new abnormality No, chest x-ray or CAT scan not performed Unknown
37. Did the patient receive a diagnosis of pneumonia?
 Yes No Unknown
38. Did the patient receive a diagnosis of ARDS?
 Yes No Unknown
39. Did the patient receive antimicrobials prior to becoming ill (within 2 weeks) or after becoming ill?
 Yes, (please complete table below) No Unknown

Drug	Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)	Total number of days receiving antivirals	Dosage (if known)
Oseltamivir (Tamiflu)				mg
Zanamivir (Relenza)				mg
Azithromycin				mg
Levofloxacin				mg
Augmentin				mg
Penicillin				mg
Other antimicrobial _____				mg
Other antimicrobial _____				mg
Other antimicrobial _____				mg

40. Did the patient die as a result of this illness?
 Yes, **Date of death:** ____/____/____ (MM/DD/YYYY) No Unknown



UAC Respiratory Disease Cluster Case Investigation Form

Medical History -- Past Medical History and Vaccination Status

41. Were any of the following chronic medical conditions noted during patient interview or recorded on the patient's medical record? Please specify **ALL** conditions noted.
- a. Asthma/reactive airway disease Yes No Unknown
 - b. Tuberculosis Yes No Unknown (If YES, specify) _____
 - c. Other chronic lung disease Yes No Unknown (If YES, specify) _____
 - d. Chronic heart or circulatory disease Yes No Unknown (If YES, specify) _____
 - e. Diabetes mellitus Yes No Unknown (If YES, specify) _____
 - f. Kidney or renal disease Yes No Unknown (If YES, specify) _____
 - g. Non-cancer immunosuppressive condition Yes No Unknown (If YES, specify) _____
 - h. Cancer chemotherapy in past 12 months Yes No Unknown (If YES, specify) _____
 - i. Neurologic/neurodevelopmental disorder Yes No Unknown (If YES, specify) _____
 - j. Cerebrospinal fluid leaks Yes No Unknown (If YES, specify) _____
 - k. Chronic liver disease Yes No Unknown (If YES, specify) _____
 - l. Sickle cell/other hemaglobinopathies Yes No Unknown (If YES, specify) _____
 - m. Congenital or acquired asplenia Yes No Unknown (If YES, specify) _____
 - n. Malnutrition Yes No Unknown (If YES, specify weight/height) _____
 - o. Other chronic diseases Yes No Unknown (If YES, specify) _____
42. Was patient pregnant or ≤ 6 weeks postpartum at illness onset?
 Yes, pregnant (weeks pregnant at onset) _____ Yes, postpartum (delivery date) ___/___/___ (MM/DD/YYYY) No Unknown
43. Does the patient currently smoke?
 Yes No Unknown
44. Was the patient vaccinated against influenza in the past year?
 Yes No (skip to Q.47) Unknown (skip to Q.47)
45. Month and year of influenza vaccination? **Vaccination date 1:** ___/___ (MM/YYYY) **Vaccination date 2:** ___/___ (MM/YYYY)
46. Type of influenza vaccine (check all that apply): Inactivated (injection) Live attenuated (nasal spray) Unknown
47. Did the patient ever receive the pneumococcal vaccine?
 Yes No (skip to Q.49) Unknown (skip to Q.49)
48. Month and year of pneumococcal vaccination? **Vaccination date 1:** ___/___ (MM/YYYY)

Specimen Testing Results

49. Was the patient tested for any pathogens? Yes (please complete table below) No Unknown
- | | Positive | Negative | Not Tested/Unknown | Collection Date | CT Value |
|--|---|--------------------------|--------------------------|-----------------|----------|
| a. Influenza | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | _____ |
| If influenza positive, specify subtype | <input type="checkbox"/> H1N1pdm09 <input type="checkbox"/> H3N2 <input type="checkbox"/> A, subtype unknown <input type="checkbox"/> Influenza B <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown | | | | |
| b. Pneumococcus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | _____ |
| c. Respiratory syncytial virus/RSV | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | _____ |
| d. Adenovirus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | _____ |
| e. Parainfluenza 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | _____ |
| f. Parainfluenza 2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | _____ |
| g. Parainfluenza 3 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | _____ |
| h. Human metapneumovirus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | _____ |
| i. Rhinovirus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | _____ |
| j. Coronavirus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | _____ |
| k. Other, specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | _____ |
| l. Other, specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | _____ |
| m. Other, specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ___/___/___ | _____ |



UAC Respiratory Disease Cluster Case Investigation Form

19. El paciente conoció a alguien que tuvo fiebre, síntomas respiratorio como tos o dolor de garganta u otro síntoma respiratorio como neumonía **7 días ANTES** del inicio de síntomas en el paciente?

- Si (**liste todos los que estuvieron enfermos antes que el paciente**)
 No
 No sabe

Nombre	Sexo (M/F)	Edad	Fecha de inicio de síntomas	Comentarios

20. Algún comentario o nota adicional?



Form Approved
OMB No. 0920-1011
Exp. Date 03/31/17

Hospitalized Case Investigation Form

Respiratory Illness

Public reporting burden of this collection of information is estimated to average 30 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 (0920-1011)



UAC Respiratory Disease Cluster Hospitalization Case Investigation Form

Alien Number _____

I. Reporter Information			
State/Territory _____		State/Territory Epi Case ID _____	
Date form completed: ____/____/____		State/Territory Lab ID _____	
Date form completed: ____/____/____		CDC Case ID _____	
Person completing form: First Name: _____ Last Name: _____ Phone: _____ Email: _____			
What are the source(s) of data for this report? (check all that apply) <input type="checkbox"/> Medical chart <input type="checkbox"/> Death certificate <input type="checkbox"/> Case report form <input type="checkbox"/> Other _____			
II. Patient Information and Medical Care			
1. Patient Date of birth: ____/____/____ (mm/dd/yyyy)			
2. Did the patient have an outpatient or ER medical care encounter during this illness?		<input type="checkbox"/> Yes, date: ____/____/____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	
3. Was the patient admitted to the hospital for this illness?		<input type="checkbox"/> Yes, date: ____/____/____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	
		Time: ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
4. Was patient hospitalized previously at another facility during this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Admission date: ____/____/____		Discharge date: ____/____/____	
Was discharge from prior hospital a transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please note initial vital signs at hospital admission/ER presentation. Date taken: ____/____/____ (mm/dd/yyyy)			
5. Body Mass	6. Height	<input type="checkbox"/> Inches <input type="checkbox"/> Height	7. Weight: <input type="checkbox"/> Lbs. <input type="checkbox"/> Weight Unknown
8. Blood Pressure ____/____	9. Respiratory Rate ____ per min	10. Heart Rate ____ beats/min	Temperature: ____°C <input type="checkbox"/> °F
11. O ₂ Sat ____%	12. Fraction of inspired oxygen ____% <input type="checkbox"/> L	13. Using: <input type="checkbox"/> O ₂ mask <input type="checkbox"/> room air <input type="checkbox"/> ventilator	
Specify O ₂ mask type: _____			
III. Illness Signs and Symptoms			
14. Please mark all signs and symptoms experienced or listed in the admission note. Date of initial symptom onset: ____/____/____			
<input type="checkbox"/> Fever (measured) highest temp. ____°C <input type="checkbox"/> °F		Date of fever onset ____/____/____ (mm/dd/yyyy)	
<input type="checkbox"/> Feverishness (temperature not measured)	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Altered mental status	
<input type="checkbox"/> Cough	<input type="checkbox"/> Chills	<input type="checkbox"/> Red or draining eyes (conjunctivitis)	
<input type="checkbox"/> With sputum (i.e., productive)	<input type="checkbox"/> Headache	<input type="checkbox"/> Abdominal pain	
<input type="checkbox"/> Hemoptysis or bloody sputum	<input type="checkbox"/> Excessive crying/fussiness (< 5 years old)	<input type="checkbox"/> Vomiting	
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Fatigue/weakness	<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Runny nose (rhinorrhea)	<input type="checkbox"/> Muscle pain/myalgia	<input type="checkbox"/> Rash, location _____	
<input type="checkbox"/> Dyspnea/difficulty breathing	Location _____	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Seizure		
IV. Patient Medical History			
15. Does the patient have any of the following pre-existing medical conditions? Check all that apply.			
15a. <input type="checkbox"/> Asthma/Reactive Airway Disease		15h. <input type="checkbox"/> Immunocompromising Condition	
15b. <input type="checkbox"/> Chronic Lung Disease		<input type="checkbox"/> HIV infection	
<input type="checkbox"/> Emphysema/COPD		<input type="checkbox"/> AIDS or CD4 count < 200	
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Stem cell transplant (e.g., bone marrow transplant)	
15c. <input type="checkbox"/> Chronic Metabolic Disease		<input type="checkbox"/> Organ transplant	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Cancer diagnosis within last 12 months (excluding non-melanoma skin cancer) Type: _____	
Insulin dependent <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Chemotherapy within last 12 months	
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Primary immune deficiency	
15d. <input type="checkbox"/> Blood disorders/Hemoglobinopathy		<input type="checkbox"/> Chronic steroid therapy (within 2 weeks of admission)	
<input type="checkbox"/> Sick cell disease		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Splenectomy/Asplenia		15i. <input type="checkbox"/> Renal Disease	
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Chronic kidney disease/chronic renal insufficiency	
		<input type="checkbox"/> End stage renal disease	
		<input type="checkbox"/> Dialysis	
		<input type="checkbox"/> Nephrotic syndrome	
		<input type="checkbox"/> Other: _____	



UAC Respiratory Disease Cluster Hospitalization Case Investigation Form

Alien Number _____

15e. Cardiovascular Disease (excluding hypertension)

- Atherosclerotic cardiovascular disease
- Cerebral vascular incident/Stroke
- With disability Yes No Unknown
- Congenital heart disease
- Coronary artery disease (CAD)
- Heart failure/Congestive heart failure
- Other: _____

15f. Neuromuscular or Neurologic disorder

- Muscular dystrophy
- Multiple sclerosis
- Mitochondrial disorder
- Myasthenia gravis
- Cerebral palsy
- Dementia
- Severe developmental delay
- Plegias/Paralysis
- Epilepsy/Seizure disorder
- Other: _____

15g. History of Guillain-Barré Syndrome

15j. Other

- Liver disease
- Scoliosis
- Obese or BMI \geq 30
- Morbidly obese or BMI \geq 40
- Down syndrome
- Pregnant, gestational age in weeks: _____ Unknown
- Post-partum (\leq 6 weeks)
- Current smoker
- Drug abuse
- Alcohol abuse
- Other: _____

PEDIATRIC CASES ONLY (<18 years old)

Abnormality of upper airway Yes No Unknown

History of febrile seizures Yes No Unknown

Premature Yes No Unknown

(gestational age < 37 weeks at birth for patients < 2yrs)

If yes, specify gestation age at birth in weeks: _____

Unknown gestational age at birth

V. Hematology and Serum Chemistries

16. Were any hematology or serum chemistries performed at hospital admission/presentation to care?

Yes No (skip to Q. 35) Unknown (skip to Q. 35)

Please note initial values at admission/presentation to care. Date values were taken: ____/____/____ (mm/dd/yyyy)

17. White blood cell count (WBC)	cells/mm ³	19. Hematocrit (Hct)	%	24. Serum creatinine	mg/dL
18. Differential:		20. Platelets (Plt)	10 ³ /mm ³	25. Serum glucose	mg/dL
Neutrophils	%	21. Sodium (Na)	U/L	26. SGPT/ALT	U/L
Bands	%	21. Potassium (K)	U/L	27. SGOT/AST	U/L
Lymphocytes	%	22. Bicarbonate (HCO₃)	U/L	28. Total bilirubin	mg/dL
Eosinophils	%	23. Serum albumin	g/dL	29. C-reactive protein (CRP)	mg/dL

Please describe other significant lab findings (e.g., CSF, protein).

Type of test	Specimen type	Date (mm/dd/yyyy)	Result
31.		/ /	
32.		/ /	
33.		/ /	
34.		/ /	

VI. Bacterial Pathogens – Sterile or respiratory site only

35. Was a pneumococcal urinary antigen test performed? Yes No Unknown

If yes, result: Positive Negative Unknown

35. Was a Legionella urinary antigen test performed? Yes No Unknown

If yes, result: Positive Negative Unknown

35. Were any bacterial culture tests performed (regardless of result)? Yes No (skip to Q.41) Unknown (skip to Q.41)

36. Indicate sites from which specimens were collected (check all that apply):

Blood Cerebrospinal fluid (CSF) Bronchoalveolar lavage (BAL)

Sputum Pleural fluid Endotracheal aspirate Other: _____

37. Was there culture confirmation of any bacterial infection? Yes No (skip to Q.41) Unknown (skip to Q.41)

38a. Positive Culture 1 collection date: ____/____/____ (mm/dd/yyyy) **38b. Specimen type:** Blood Cerebrospinal fluid (CSF) Bronchoalveolar lavage (BAL)

Sputum Pleural fluid Endotracheal aspirate Other: _____

38c. Pathogen(s) identified: *S. aureus* *S. pyogenes* *S. pneumoniae* *H. influenzae* Other: _____

38d. If Staphylococcus aureus, specify: Methicillin resistant (MRSA) Methicillin sensitive (MSSA) Sensitivity unknown

39a. Positive Culture 2 collection date: ____/____/____ (mm/dd/yyyy) **39b. Specimen type:** Blood Cerebrospinal fluid (CSF) Bronchoalveolar lavage (BAL)

Sputum Pleural fluid Endotracheal aspirate Other: _____

39c. Pathogen(s) identified: *S. aureus* *S. pyogenes* *S. pneumoniae* *H. influenzae* Other: _____

39d. If Staphylococcus aureus, specify: Methicillin resistant (MRSA) Methicillin sensitive (MSSA) Sensitivity unknown



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40a. Positive Culture 3 collection date: _____ / _____ / _____ (mm/dd/yyyy)

40b. Specimen type: Blood Cerebrospinal fluid (CSF) Bronchoalveolar lavage (BAL)
 Sputum Pleural fluid Endotracheal aspirate Other: _____

40c. Pathogen(s) identified: *S. aureus* *S. pyogenes* *S. pneumoniae* *H. influenzae* Other: _____

40d. If *Staphylococcus aureus*, specify: Methicillin resistant (MRSA) Methicillin sensitive (MSSA) Sensitivity unknown

VII. Respiratory Viral Pathogens

41. Was the patient tested for any other viral pathogens? Yes No (skip to Q.42) Unknown (skip to Q.42)

	Positive	Negative	Not Tested/Unknown	Collection Date	Specimen Type
a. Respiratory syncytial virus/RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
b. Adenovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
c. Parainfluenza 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
d. Parainfluenza 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
e. Parainfluenza 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
f. Human metapneumovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
g. Rhinovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
h. Coronavirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
i. Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
j. Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____

VIII. Medications

42. Did the patient receive influenza antiviral medications during illness? Yes No Unknown

	Date started	Date stopped	Frequency	Dose
Osetamivir (Tamiflu) <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Inhaled	____/____/____	____/____/____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID	
Zanamivir (Relenza) <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Inhaled	____/____/____	____/____/____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID	
Peramivir <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Inhaled	____/____/____	____/____/____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID	
Other influenza antiviral: _____ <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Inhaled	____/____/____	____/____/____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID	
Other influenza antiviral: _____ <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Inhaled	____/____/____	____/____/____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID	

43. Did the patient receive antibiotics during the illness? Yes No Unknown

If yes, name	Date started	Date stopped	Dose
<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	____/____/____	____/____/____	
<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	____/____/____	____/____/____	
<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	____/____/____	____/____/____	
<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	____/____/____	____/____/____	
<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	____/____/____	____/____/____	

44. Did the patient receive steroids (excluding inhaled steroids or one time injections) or other immune modulating treatment specifically for this illness? Yes No Unknown

If yes, name	Date started	Date stopped	Dose
<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	____/____/____	____/____/____	
<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	____/____/____	____/____/____	
<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	____/____/____	____/____/____	

45. Additional treatment comments:

IX. Chest Radiograph – Based on final impression/conclusion of the radiology report Please include a copy of the radiology report with the form.

46. Did the patient have a chest x-ray within 3 days of admission? Yes, date ____/____/____ No (skip to Q.52) Unknown (skip to Q.52)

47. If yes, was the chest x-ray abnormal? Yes, date ____/____/____ No (skip to Q.52) Unknown (skip to Q.52)

48. For the abnormal chest x-ray, please transcribe the final impression/conclusion and check all that apply:

Final impression/conclusion:



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<input type="checkbox"/> Consolidation: →	<input type="checkbox"/> Single lobar infiltrate	<input type="checkbox"/> Multi-lobar infiltrate (unilateral)	<input type="checkbox"/> Multi-lobar infiltrate (bilateral)
	<input type="checkbox"/> Lobar or segmental collapse	<input type="checkbox"/> Cavitation/Abscess/Necrosis	<input type="checkbox"/> Round pneumonia
<input type="checkbox"/> Other Infiltrate: →	<input type="checkbox"/> Alveolar (air space) disease	<input type="checkbox"/> Interstitial disease	<input type="checkbox"/> Mixed (airspace and interstitial) disease
<input type="checkbox"/> Pleural Effusion: →	<input type="checkbox"/> Unilateral	<input type="checkbox"/> Bilateral	
<input type="checkbox"/> Bronchiolitis: →	<input type="checkbox"/> Complicated	<input type="checkbox"/> Uncomplicated	
<input type="checkbox"/> Other: →	<input type="checkbox"/> Air leak/Pneumothorax	<input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Chest wall invasion
	<input type="checkbox"/> Specify: _____		

49. Did the patient have another chest x-ray within 3

days of admission? Yes, date ____/____/____ No (skip to Q.52) Unknown (skip to Q.52)

50. If yes, was the chest x-ray abnormal? Yes, date ____/____/____ No (skip to Q.52) Unknown (skip to Q.52)

51. For the abnormal chest x-ray, please transcribe the final impression/conclusion and check all that apply:

Final impression/conclusion:

<input type="checkbox"/> Consolidation: →	<input type="checkbox"/> Single lobar infiltrate	<input type="checkbox"/> Multi-lobar infiltrate (unilateral)	<input type="checkbox"/> Multi-lobar infiltrate (bilateral)
	<input type="checkbox"/> Lobar or segmental collapse	<input type="checkbox"/> Cavitation/Abscess/Necrosis	<input type="checkbox"/> Round pneumonia
<input type="checkbox"/> Other Infiltrate: →	<input type="checkbox"/> Alveolar (air space) disease	<input type="checkbox"/> Interstitial disease	<input type="checkbox"/> Mixed (airspace and interstitial) disease
<input type="checkbox"/> Pleural Effusion: →	<input type="checkbox"/> Unilateral	<input type="checkbox"/> Bilateral	
<input type="checkbox"/> Bronchiolitis: →	<input type="checkbox"/> Complicated	<input type="checkbox"/> Uncomplicated	
<input type="checkbox"/> Other: →	<input type="checkbox"/> Air leak/Pneumothorax	<input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Chest wall invasion
	<input type="checkbox"/> Specify: _____		

**X. Chest CT or MRI – Based on final impression/conclusion of the radiology report
please include a copy of the radiology report with the form.**

52. Did the patient have a chest CT/MRI scan within

3 days of admission? Yes, date ____/____/____ No (skip to Q.56) Unknown (skip to Q.56)

52. If yes, please select one: CT: contrast CT: non-contrast MRI

54. If yes, was the CT/MRI abnormal? Yes, date ____/____/____ No (skip to Q.56) Unknown (skip to Q.56)

55. For abnormal chest CT/ MRI, please check all that apply and please transcribe the final impression/conclusion:

Final impression/conclusion:

<input type="checkbox"/> Consolidation: →	<input type="checkbox"/> Single lobar infiltrate	<input type="checkbox"/> Multi-lobar infiltrate (unilateral)	<input type="checkbox"/> Multi-lobar infiltrate (bilateral)
	<input type="checkbox"/> Lobar or segmental collapse	<input type="checkbox"/> Cavitation/Abscess/Necrosis	<input type="checkbox"/> Round pneumonia
<input type="checkbox"/> Other Infiltrate: →	<input type="checkbox"/> Alveolar (air space) disease	<input type="checkbox"/> Interstitial disease	<input type="checkbox"/> Mixed (airspace and interstitial) disease
<input type="checkbox"/> Pleural Effusion: →	<input type="checkbox"/> Unilateral	<input type="checkbox"/> Bilateral	
<input type="checkbox"/> Bronchiolitis: →	<input type="checkbox"/> Complicated	<input type="checkbox"/> Uncomplicated	
<input type="checkbox"/> Other: →	<input type="checkbox"/> Air leak/Pneumothorax	<input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Chest wall invasion
	<input type="checkbox"/> Specify: _____		

XI. Clinical Course and Severity of Illness

56. At any time during the current illness, did the patient require or have the diagnosis of :

a. Admission to intensive care unit (ICU) Yes No Unknown

Admission date: ____/____/____ Discharge date: ____/____/____
If multiple admissions, 2nd ICU admission date: ____/____/____ 2nd ICU discharge date: ____/____/____

If more than 2 ICU admissions, please provide dates in the comments section (Q.66)

b. Supplemental oxygen Yes No Unknown

Date started: ____/____/____ Date stopped: ____/____/____

c. Ventilatory support Yes No Unknown

Check all that apply: Intubation Date started: ____/____/____ Date stopped: ____/____/____
 ECMO Date started: ____/____/____ Date stopped: ____/____/____
 CPAP Date started: ____/____/____ Date stopped: ____/____/____



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BiPAP Date started: ___/___/___ Date stopped: ___/___/___

d. Vasopressor medications (e.g. dopamine, epinephrine)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Date started: ___/___/___	Date stopped: ___/___/___		
e. Dialysis (Acute)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Date started: ___/___/___	Date stopped: ___/___/___		
f. Resuscitation, CPR	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
g. Acute respiratory distress syndrome (ARDS)	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
h. Disseminated intravascular coagulopathy (DIC)	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
i. Hemophagocytic syndrome	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
j. Bronchiolitis	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
k. Pneumonia	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
l. Stroke (Acute)	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
m. Sepsis	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
n. Shock	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
Type: <input type="checkbox"/> hypovolemic <input type="checkbox"/> cardiogenic <input type="checkbox"/> septic <input type="checkbox"/> toxic			
o. Acute myocarditis	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
p. Acute myocardial dysfunction	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
q. Acute myocardial infarction	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
r. Seizures	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
s. Reye's syndrome	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
t. Acute encephalitis / encephalopathy	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
u. Guillain-Barre syndrome	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
v. Rhabdomyolysis	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
w. Acute liver impairment	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
x. Acute renal failure	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Unknown
y. Other, specify: _____	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	
z. Other, specify: _____	<input type="checkbox"/> Yes, date started: ___/___/___	stopped: ___/___/___	

XII. Outcomes

57. Did the patient die during this illness? Yes, date ___/___/___ No (skip to Q.62) Unknown (skip to Q.62)

58. What was the location of death? Home Hospital ER Hospice Other, specify _____

59. Did the patient have a DNR (do not resuscitate) order? Yes No Unknown

60. Was an autopsy performed? Yes (please attach a copy of the autopsy form to this report if available) No Unknown

61. What were the causes of death (immediate and underlying) in order of appearance on the death certificate or medical record?

1.	4.	7.
2.	5.	8.
3.	6.	9.

62. Has the patient been discharged from the hospital? Yes, date ___/___/___ No Unknown

63. If yes, please indicate to where: Home Other hospital Hospice Rehabilitation Facility
 Other long-term care facility Other, specify: _____ Unknown

63. If no, please indicate status: Hospitalized on ward Hospitalized in ICU Died

64. If patient was pregnant, please indicate pregnancy status at discharge or final update:

Still pregnant Uncomplicated labor/delivery Complicated labor/delivery Fetal loss
Describe _____ Date ___/___/___

64. If pregnancy resulted in delivery, please indicate neonatal outcome: Birth date: ___/___/___

Healthy newborn Ill newborn, describe: _____ Newborn died: Date ___/___/___ Unknown

65. Additional notes regarding discharge:

XIII. Additional Comments

66. Additional Comments:

Verbal Consent / Assent Script

Hi, my name is _____. I'm working with the health department and this shelter to find out what has been making some children here sick with fever and cough. We'd like to ask you some questions about the symptoms you've had in the last week. We will swab your nose and throat to test for any germs that might be making you sick. You don't have to answer our questions or allow us to swab your nose and throat; you can decide if you want to talk to us and let us swab you. We can answer any questions that you have about the study and procedures. Do you have any questions?

May I ask you some questions now? Yes No

(Complete questionnaire)

May I swab your nose and throat now? Yes No

Place sticker with Alien number here,
DO NOT PUT CHILD's NAME ON THIS FORM

Verbal consent obtained by: _____ Date: _____

Consentimiento Verbal

El párrafo a continuación se leerá al entrevistado y las respuestas serán registradas por el entrevistador:

Hola, me llamo _____, estoy trabajando con el departamento de salud y este refugio para tratar de entender por qué algunos niños de éste refugio se están enfermado con fiebre y con tos. Nos gustaría hacerte algunas preguntas sobre los síntomas que has tenido la semana pasada. Vamos a pasarte un hisopo por la nariz y por la garganta para detectar algunos gérmenes que podrían estar enfermándote. No tienes que responder a nuestras preguntas o dejarte pasar el hisopo si no quieres; o si quieres podemos hacerte las preguntas y pasar un hisopo por la nariz y garganta. Podemos responder a cualquier pregunta que tengas sobre este estudio y los procedimientos. Tienes alguna pregunta?

¿Puedo hacerte algunas preguntas ahora? Sí No

(Cuestionario completo)

¿Puedo pasar el hisopo por la nariz y garganta ahora? Sí No

Place sticker with Alien number here,
DO NOT PUT CHILD'S NAME ON THIS FORM

El consentimiento verbal fue obtenido por: _____ Fecha: _____