

SEVERE ACUTE RESPIRATORY SYNDROME (SARS)
CASE REPORTING FORM*

Identification Number: 1

Date of Report: 03/02/2004
m m d d . y y y y

Submitted By:	
Last Name: <u>DOE</u>	First Name: <u>JANE</u>
State: <u>CALIFORNIA</u>	Affiliation: <u>ALTA BATES</u>
Phone: <u>(510) 555-1212</u>	E-mail: <u>JANE.DOE@SOMEWHERE.COM</u>

1.0 Patient Information:

1.1. Patient's Last Name: FLINTSTONE First Name: FRED

1.2. Current Street Address: 1212 SHATTUCK AVENUE

City: BERKELEY State: CA Zip Code: 94720

County: ALAMEDA

1.3. Home telephone: (510) 555-1000 Work telephone: (510) 555-2000

1.4. Age at Onset: 42 Years Months

1.5. Gender: Male
 Female

1.6. Ethnicity: Hispanic/Latino
 Non-Hispanic/Non-Latino

1.7. Race (Check all that apply):
 Native American/
Alaskan Native White
 African American/Black Other
 Asian Pacific Islander
 Unknown

1.8. Residency: U.S. Resident
 Non-U.S. Resident

1.9. Is the individual a healthcare worker?
 Yes
 No
 Unknown

1.9a. If yes, specify type:
 Physician Nurse/PA
 Laboratory Resp. Therapist
 Radiology Tech Other

1.10. Does the patient have DIRECT patient care responsibilities?
 Yes
 No
 Unknown

2.0 Signs and Symptoms:

2.1. Date of Initial Symptom Onset:

03/01/2004
m m d d y y y y

2.2. Did the person have a fever (subjective or objective)?

- Yes
 No
 Unknown

2.2a. If yes, date of fever onset: 03/01/2004
m m d d y y y y

2.2b. If yes, what was the temperature (in °F)? 101°

2.3. Did the person have any of the following symptoms?

- | | | | |
|-------------------------------|-----------------------------------------|----------------------------------------|----------------------------------|
| 2.3a Chills? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3b Rigors? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3c Myalgia? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3d Headache? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3e Diarrhea? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3f Sore Throat? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3g Rhinorrhea (runny nose)? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

3.0 SARS Epidemiological Risk Factors

3.1. Is the patient a close contact to an identified pneumonia cluster or person with unexplained pneumonia? Yes No Unknown

3.2. In the 10 days prior to symptom onset, did the patient have close contact to a laboratory-confirmed SARS case? Yes No Unknown

3.2a. If yes, please complete the following:

Contact Information #1:

Contact Last Name: _____

Contact First Name: _____

- Classification of Contact:
- RUI-2
 - RUI-3
 - Probable SARS CoV case
 - Confirmed SARS CoV case

- Nature of Contact:
- Same household
 - Coworker
 - Healthcare environment
 - Other _____

Did the ill contact recently travel to an area with SARS transmission?

- Yes No Unknown

Contact Information #2:

Contact Last Name: _____

Contact First Name: _____

Classification of Contact: RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

Nature of Contact: Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

Contact Information #3:

Contact Last Name: _____

Contact First Name: _____

Classification of Contact: RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

Nature of Contact: Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

Contact Information #4:

Contact Last Name: _____

Contact First Name: _____

Classification of Contact: RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

Nature of Contact: Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

3.3. In the 10 days prior to symptom onset, did the patient travel to a foreign or domestic location with recent documented or suspected local transmission of SARS?

Yes No Unknown

3.3a. If yes, which area(s)? _____

3.3b. If yes, please complete the following:

Departure Date (mm/dd/yyyy)	Departure City	Arrival City	Arrival Date (mm/dd/yyyy)	Transport Type

4.0 Laboratory Evaluation

Choose from the following specimens to enter for each test: whole blood, serum (acute), serum (convalescent), NP swab, NP aspirate, bronchoalveolar lavage specimen, OP swab, urine, stool, or tissue.

Specimen	Date Collected (mm/dd/yyyy)	Test Requested	Result
SERUM (ACUTE)	03/01/2004	EIA	PENDING

* This form is a modified version of the draft SARS Surveillance Case Report Form provided by the Centers for Disease Control and Prevention. For the more complete version of the surveillance form, go to: <http://www.cdc.gov/ncidod/sars/guidance/B/pdf/app2.pdf> (last accessed 03.07.2004).

SEVERE ACUTE RESPIRATORY SYNDROME (SARS)
CASE REPORTING FORM*

Identification Number: 2

Date of Report: 03 / 05 / 2004
m m d d y y y y

Submitted By:	
Last Name: <u>DOE</u>	First Name: <u>JANE</u>
State: <u>CALIFORNIA</u>	Affiliation: <u>ALTA BATES</u>
Phone: <u>(510) 555-1212</u>	E-mail: <u>JANE.DOE@SOMEWHERE.COM</u>

1.0 Patient Information:

1.1. Patient's Last Name: SMITH First Name: JOHN

1.2. Current Street Address: 612 CHANNING WAY, APT B

City: BERKELEY State: CA Zip Code: 94720

County: ALAMEDA

1.3. Home telephone: (510) 555-7000 Work telephone: (510) 555-5000

1.4. Age at Onset: 23 Years Months

1.5. Gender: Male
 Female

1.6. Ethnicity: Hispanic/Latino
 Non-Hispanic/Non-Latino

1.7. Race (Check all that apply):

- | | |
|-------------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Native American/
Alaskan Native | <input checked="" type="checkbox"/> White |
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Pacific Islander |
| | <input type="checkbox"/> Unknown |

1.8. Residency:

- U.S. Resident
 Non-U.S. Resident

1.9. Is the individual a healthcare worker?

- Yes
 No
 Unknown

1.9a. If yes, specify type:

- | | |
|-----------------------------------------|------------------------------------------|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Nurse/PA |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Resp. Therapist |
| <input type="checkbox"/> Radiology Tech | <input type="checkbox"/> Other |

1.10. Does the patient have DIRECT patient care responsibilities?

- Yes
 No
 Unknown

2.0 Signs and Symptoms:

2.1. Date of Initial Symptom Onset:

03 / 04 / 2004
m m d d y y y y

2.2. Did the person have a fever (subjective or objective)?

- Yes
- No
- Unknown

2.2a. If yes, date of fever onset: / /
m m d d y y y y

2.2b. If yes, what was the temperature (in °F)?

2.3. Did the person have any of the following symptoms?

- 2.3a Chills? Yes No Unknown
- 2.3b Rigors? Yes No Unknown
- 2.3c Myalgia? Yes No Unknown
- 2.3d Headache? Yes No Unknown
- 2.3e Diarrhea? Yes No Unknown
- 2.3f Sore Throat? Yes No Unknown
- 2.3g Rhinorrhea (runny nose)? Yes No Unknown

3.0 SARS Epidemiological Risk Factors

3.1. Is the patient a close contact to an identified pneumonia cluster or person with unexplained pneumonia? Yes No Unknown

3.2. In the 10 days prior to symptom onset, did the patient have close contact to a laboratory-confirmed SARS case? Yes No Unknown

3.2a. If yes, please complete the following:

Contact Information #1:

Contact Last Name: GOLDENSON

Contact First Name: JIM

- Classification of Contact:
- RUI-2
 - RUI-3
 - Probable SARS CoV case
 - Confirmed SARS CoV case

- Nature of Contact:
- Same household
 - Coworker
 - Healthcare environment
 - Other

Did the ill contact recently travel to an area with SARS transmission? Yes No Unknown

Contact Information #2:

Contact Last Name: _____

Contact First Name: _____

Classification of Contact: RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

Nature of Contact: Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

Contact Information #3:

Contact Last Name: _____

Contact First Name: _____

Classification of Contact: RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

Nature of Contact: Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

Contact Information #4:

Contact Last Name: _____

Contact First Name: _____

Classification of Contact: RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

Nature of Contact: Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

3.3. In the 10 days prior to symptom onset, did the patient travel to a foreign or domestic location with recent documented or suspected local transmission of SARS?

Yes No Unknown

3.3a. If yes, which area(s)? _____

3.3b. If yes, please complete the following:

Departure Date (mm/dd/yyyy)	Departure City	Arrival City	Arrival Date (mm/dd/yyyy)	Transport Type

4.0 Laboratory Evaluation

Choose from the following specimens to enter for each test: whole blood, serum (acute), serum (convalescent), NP swab, NP aspirate, bronchoalveolar lavage specimen, OP swab, urine, stool, or tissue.

Specimen	Date Collected (mm/dd/yyyy)	Test Requested	Result
SERUM (ACUTE)	03/04/2004	EIA	PENDING

* This form is a modified version of the draft SARS Surveillance Case Report Form provided by the Centers for Disease Control and Prevention. For the more complete version of the surveillance form, go to: <http://www.cdc.gov/ncidod/sars/guidance/B/pdf/app2.pdf> (last accessed 03.07.2004).

SEVERE ACUTE RESPIRATORY SYNDROME (SARS)
CASE REPORTING FORM*

Identification Number: 3

Date of Report: 03/01/2004
m m d d y y y y

Submitted By:	
Last Name: <u>DOE</u>	First Name: <u>JANE</u>
State: <u>CALIFORNIA</u>	Affiliation: <u>ALTA BATES</u>
Phone: <u>(510) 555-1212</u>	E-mail: <u>JANE.DOE@SOMEWHERE.COM</u>

1.0 Patient Information:

1.1. Patient's Last Name: GOLDENSON First Name: JIM

1.2. Current Street Address: 612 CHANNING WAY, APT B

City: BERKELEY State: CA Zip Code: 94720

County: ALAMEDA

1.3. Home telephone: (510) 555-4000 Work telephone: (510) 555-1256

1.4. Age at Onset: 25 Years Months

1.5. Gender: Male
 Female

1.6. Ethnicity: Hispanic/Latino
 Non-Hispanic/Non-Latino

1.7. Race (Check all that apply):

- | | |
|-------------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Native American/
Alaskan Native | <input checked="" type="checkbox"/> White |
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Pacific Islander |
| | <input type="checkbox"/> Unknown |

1.8. Residency:

- U.S. Resident
 Non-U.S. Resident

1.9. Is the individual a healthcare worker?

- Yes
 No
 Unknown

1.9a. If yes, specify type:

- | | |
|-----------------------------------------|------------------------------------------|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Nurse/PA |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Resp. Therapist |
| <input type="checkbox"/> Radiology Tech | <input type="checkbox"/> Other |

1.10. Does the patient have DIRECT patient care responsibilities?

- Yes
 No
 Unknown

2.0 Signs and Symptoms:

2.1. Date of Initial Symptom Onset:

02/28/2004
m m d d y y y y

2.2. Did the person have a fever (subjective or objective)?

- Yes
 No
 Unknown

2.2a. If yes, date of fever onset: 02/28/2004
m m d d y y y y

2.2b. If yes, what was the temperature (in °F)? 102°

2.3. Did the person have any of the following symptoms?

- | | | | |
|-------------------------------|-----------------------------------------|-----------------------------|----------------------------------|
| 2.3a Chills? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3b Rigors? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3c Myalgia? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3d Headache? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3e Diarrhea? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3f Sore Throat? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3g Rhinorrhea (runny nose)? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

3.0 SARS Epidemiological Risk Factors

3.1. Is the patient a close contact to an identified pneumonia cluster or person with unexplained pneumonia? Yes No Unknown

3.2. In the 10 days prior to symptom onset, did the patient have close contact to a laboratory-confirmed SARS case? Yes No Unknown

3.2a. If yes, please complete the following:

Contact Information #1:

Contact Last Name: _____

Contact First Name: _____

- Classification of Contact:
- RUI-2
 - RUI-3
 - Probable SARS CoV case
 - Confirmed SARS CoV case

- Nature of Contact:
- Same household
 - Coworker
 - Healthcare environment
 - Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

Contact Information #2:

Contact Last Name: _____

Contact First Name: _____

Classification of Contact: RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

Nature of Contact: Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

Contact Information #3:

Contact Last Name: _____

Contact First Name: _____

Classification of Contact: RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

Nature of Contact: Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

Contact Information #4:

Contact Last Name: _____

Contact First Name: _____

Classification of Contact: RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

Nature of Contact: Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

3.3. In the 10 days prior to symptom onset, did the patient travel to a foreign or domestic location with recent documented or suspected local transmission of SARS?

Yes No Unknown

3.3a. If yes, which area(s)? CHINA - GUANGDONG PROVINCE

3.3b. If yes, please complete the following:

Departure Date (mm/dd/yyyy)	Departure City	Arrival City	Arrival Date (mm/dd/yyyy)	Transport Type

4.0 Laboratory Evaluation

Choose from the following specimens to enter for each test: whole blood, serum (acute), serum (convalescent), NP swab, NP aspirate, bronchoalveolar lavage specimen, OP swab, urine, stool, or tissue.

Specimen	Date Collected (mm/dd/yyyy)	Test Requested	Result
SERUM (ACUTE)	02/28/2004	EIA	PENDING

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SEVERE ACUTE RESPIRATORY SYNDROME (SARS)
CASE REPORTING FORM*

Identification Number: 7

Date of Report: 03/10/2004
m m d d y y y y

Submitted By:	
Last Name: <u>SALAZAR</u>	First Name: <u>MARTINE</u>
State: <u>CALIFORNIA</u>	Affiliation: <u>VA HOSPITAL</u>
Phone: <u>(415) 555-2346</u>	E-mail: <u>MARTINE.SALAZAR@NOWHERE.COM</u>

1.0 Patient Information:

1.1. Patient's Last Name: GUERRERO First Name: JULIO

1.2. Current Street Address: 1000 BAY STREET

City: SAN FRANCISCO State: CA Zip Code: 94141

County: SAN FRANCISCO

1.3. Home telephone: (415) 555-2939 Work telephone: (415) 555-2636

1.4. Age at Onset: 52 Years Months

1.5. Gender: Male
 Female

1.6. Ethnicity: Hispanic/Latino
 Non-Hispanic/Non-Latino

1.7. Race (Check all that apply):

- | | |
|-------------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Native American/
Alaskan Native | <input checked="" type="checkbox"/> White |
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Pacific Islander |
| | <input type="checkbox"/> Unknown |

1.8. Residency:

- U.S. Resident
 Non-U.S. Resident

1.9. Is the individual a healthcare worker?

- Yes
 No
 Unknown

1.9a. If yes, specify type:

- | | |
|-----------------------------------------|------------------------------------------|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Nurse/PA |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Resp. Therapist |
| <input type="checkbox"/> Radiology Tech | <input type="checkbox"/> Other |

1.10. Does the patient have DIRECT patient care responsibilities?

- Yes
 No
 Unknown

2.0 Signs and Symptoms:

2.1. Date of Initial Symptom Onset:

03 / 09 / 2004
m m d d y y y y

2.2. Did the person have a fever (subjective or objective)?

- Yes
 No
 Unknown

2.2a. If yes, date of fever onset: 03 / 09 / 2004
m m d d y y y y

2.2b. If yes, what was the temperature (in °F)? 102°

2.3. Did the person have any of the following symptoms?

- | | | | |
|-------------------------------|-----------------------------------------|----------------------------------------|----------------------------------|
| 2.3a Chills? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3b Rigors? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3c Myalgia? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3d Headache? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3e Diarrhea? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3f Sore Throat? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3g Rhinorrhea (runny nose)? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

3.0 SARS Epidemiological Risk Factors

3.1. Is the patient a close contact to an identified pneumonia cluster or person with unexplained pneumonia? Yes No Unknown

3.2. In the 10 days prior to symptom onset, did the patient have close contact to a laboratory-confirmed SARS case? Yes No Unknown

3.2a. If yes, please complete the following:

Contact Information #1:

Contact Last Name: GOLDENSON

Contact First Name: JM

- Classification of Contact:
- RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

- Nature of Contact:
- Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

Contact Information #2:

Contact Last Name: _____

Contact First Name: _____

Classification of Contact: RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

Nature of Contact: Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

Contact Information #3:

Contact Last Name: _____

Contact First Name: _____

Classification of Contact: RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

Nature of Contact: Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

Contact Information #4:

Contact Last Name: _____

Contact First Name: _____

Classification of Contact: RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

Nature of Contact: Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

3.3. In the 10 days prior to symptom onset, did the patient travel to a foreign or domestic location with recent documented or suspected local transmission of SARS?

Yes No Unknown

3.3a. If yes, which area(s)? _____

3.3b. If yes, please complete the following:

Departure Date (mm/dd/yyyy)	Departure City	Arrival City	Arrival Date (mm/dd/yyyy)	Transport Type

4.0 Laboratory Evaluation

Choose from the following specimens to enter for each test: whole blood, serum (acute), serum (convalescent), NP swab, NP aspirate, bronchoalveolar lavage specimen, OP swab, urine, stool, or tissue.

Specimen	Date Collected (mm/dd/yyyy)	Test Requested	Result
SERUM (ACUTE)	03/09/2007	EIA	PENDING

* This form is a modified version of the draft SARS Surveillance Case Report Form provided by the Centers for Disease Control and Prevention. For the more complete version of the surveillance form, go to: <http://www.cdc.gov/ncidod/sars/guidance/B/pdf/app2.pdf> (last accessed 03.07.2004).

SEVERE ACUTE RESPIRATORY SYNDROME (SARS)
CASE REPORTING FORM*

Identification Number: 5

Date of Report: 03/10/2004
m m d d y y y y

Submitted By:	
Last Name: <u>DELA CRUZ</u>	First Name: <u>GERRY</u>
State: <u>CALIFORNIA</u>	Affiliation: <u>HIGHLAND HOSPITAL</u>
Phone: <u>(510) 555-9876</u>	E-mail: <u>GERRY.DELA CRUZ@HOME.COM</u>

1.0 Patient Information:

1.1. Patient's Last Name: SMITH First Name: FLORENCE

1.2. Current Street Address: 2020 BROADWAY ST.

City: OAKLAND State: CA Zip Code: 94121

County: ALAMEDA

1.3. Home telephone: (510) 555-6262 Work telephone: (510) 555-6363

1.4. Age at Onset: 32 Years Months

1.5. Gender: Male
 Female

1.6. Ethnicity: Hispanic/Latino
 Non-Hispanic/Non-Latino

1.7. Race (Check all that apply):

- | | |
|-------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Native American/
Alaskan Native | <input type="checkbox"/> White |
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Pacific Islander |
| | <input checked="" type="checkbox"/> Unknown |

1.8. Residency:

- U.S. Resident
 Non-U.S. Resident

1.9. Is the individual a healthcare worker?

- Yes
 No
 Unknown

1.9a. If yes, specify type:

- | | |
|------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Nurse/PA |
| <input checked="" type="checkbox"/> Laboratory | <input type="checkbox"/> Resp. Therapist |
| <input type="checkbox"/> Radiology Tech | <input type="checkbox"/> Other |

1.10. Does the patient have DIRECT patient care responsibilities?

- Yes
 No
 Unknown

2.0 Signs and Symptoms:

2.1. Date of Initial Symptom Onset:

03/09/2004
m m d d y y y y

2.2. Did the person have a fever (subjective or objective)?

- Yes
 No
 Unknown

2.2a. If yes, date of fever onset: 03/09/2004
m m d d y y y y

2.2b. If yes, what was the temperature (in °F)? 101°

2.3. Did the person have any of the following symptoms?

- | | | | |
|-------------------------------|-----------------------------------------|----------------------------------------|----------------------------------|
| 2.3a Chills? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3b Rigors? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3c Myalgia? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3d Headache? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3e Diarrhea? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3f Sore Throat? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2.3g Rhinorrhea (runny nose)? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

3.0 SARS Epidemiological Risk Factors

3.1. Is the patient a close contact to an identified pneumonia cluster or person with unexplained pneumonia? Yes No Unknown

3.2. In the 10 days prior to symptom onset, did the patient have close contact to a laboratory-confirmed SARS case? Yes No Unknown

3.2a. If yes, please complete the following:

Contact Information #1:

Contact Last Name: _____

Contact First Name: _____

- Classification of Contact:
- RUI-2
 - RUI-3
 - Probable SARS CoV case
 - Confirmed SARS CoV case

- Nature of Contact:
- Same household
 - Coworker
 - Healthcare environment
 - Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

Contact Information #2:

Contact Last Name: _____

Contact First Name: _____

Classification of Contact: RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

Nature of Contact: Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

Contact Information #3:

Contact Last Name: _____

Contact First Name: _____

Classification of Contact: RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

Nature of Contact: Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

Contact Information #4:

Contact Last Name: _____

Contact First Name: _____

Classification of Contact: RUI-2
 RUI-3
 Probable SARS CoV case
 Confirmed SARS CoV case

Nature of Contact: Same household
 Coworker
 Healthcare environment
 Other _____

Did the ill contact recently travel to an area with SARS transmission?
 Yes No Unknown

3.3. In the 10 days prior to symptom onset, did the patient travel to a foreign or domestic location with recent documented or suspected local transmission of SARS?

Yes No Unknown

3.3a. If yes, which area(s)? _____

3.3b. If yes, please complete the following:

Departure Date (mm/dd/yyyy)	Departure City	Arrival City	Arrival Date (mm/dd/yyyy)	Transport Type

4.0 Laboratory Evaluation

Choose from the following specimens to enter for each test: whole blood, serum (acute), serum (convalescent), NP swab, NP aspirate, bronchoalveolar lavage specimen, OP swab, urine, stool, or tissue.

Specimen	Date Collected (mm/dd/yyyy)	Test Requested	Result
SERUM (ACUTE)	03/09/2004	EIA	PENDING

* This form is a modified version of the draft SARS Surveillance Case Report Form provided by the Centers for Disease Control and Prevention. For the more complete version of the surveillance form, go to: <http://www.cdc.gov/ncidod/sars/guidance/B/pdf/app2.pdf> (last accessed 03.07.2004).