Form Approved OMB No. 0920-0009

Hantavirus Pulmonary Syndrome Case Report Form

Please return to: Centers for Disease Control and Prevention, Special Pathogens Branch
Ph: (404) 639-1510 Fax: (404) 639-1118 Email: dvd1spath@cdc.gov
Site: www.cdc.gov/ncidod/diseases/hanta/hps/noframes/phys/specimen/hlthdept.htm

Patient Identification

				-FIPS-		-YR-	

Information below is required for identification and meaningful interpretation of laboratory diagnostic results. HPS may not be confirmed without compatible clinical and/or exposure data.

PATIENT INFORMATION

Last name:

First name: MI:

Age: Sex: Choose one

Street address:

City/town:

County:

State: ZIP:

PATIENT'S BACKGROUND and EXPOSURE INFORMATION

Occupation:

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian/other Pacific Islander

Ethnicity: Choose one

History of rodent exposure in 6 weeks prior to onset of illness? Choose one

If yes, type of rodent? Choose one

Place of contact (town, county, state):

Notes:

TIMELINE

Date of onset of symptoms: _____ Patient hospitalized? Choose one Date of hospitalization: _____

CLINICAL INFORMATION

Fever > 101°F (38.3°C)? Choose one

Thrombocytopenia? (platelets <150,000mm) Choose one

Lowest platelet count measured: _____

Elevated hematocrit (Hct)? Choose one

Highest hematocrit measured: _____

Elevated creatinine? Choose one

Highest creatinine measured: _____

WBC total: _____
Total neutrophils: _____ %
Band neutrophils: _____ %
Lymphocytes: _____ %

CLINICAL INFORMATION

Supplemental oxygen required? Choose one

Was patient intubated? Choose one

CXR with unexplained bilateral interstitial infiltrates or suggestive of ARDS? Choose one

OUTCOME

Outcome of illness? Choose one

Date of death: _____

Autopsy performed? Choose one

Notes:

SPECIMEN INFORMATION

Specimen acquisition date: _____

Type of specimen: _____

Has specimen been tested for hantavirus at a laboratory? Choose one

If yes, where? _____

Results (i.e., titer, OD): _____

FOR STATE HEALTH DEPARTMENTS

State Health Department reporting case: _____ State/local ID number: _____ Date form completed: _____

Person completing Report: _____ Phone number: _____

Name of patient's physician: _____ Phone number: _____

Instructions: You must have internet access and an email address to submit this Form electronically. Upon hitting the 'Submit by Email' button, a PDF is created, attached to an email, which you should then send to the address which appears in the address header; you may also cc: others. Acknowledgement of receipt by CDC is not provided.

Submit by Email

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0009).