DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
ATLANTA, GA 30329

Reset Form

Form Approved OMB No. 0920-0728

Hantavirus Disease Case Report Form

Please return to: Centers for Disease Control and Prevention, Viral Special Pathogens Branch
Ph: (470) 312-0094 Fax: (404) 471-2526 Email: spather@cdc.gov
Site: http://www.cdc.gov/hantavirus/health-care-workers/specimen-submission/index.html

Patient Identification

-FIPS- _____ -YR- _____

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

PATIENT INFORMATION

Last name: _____

First name: _____ MI: _____

Age: _____ Sex: _____

City/town: _____

County: _____

State: _____ ZIP: _____

Choose one (if known):

☐ Hantavirus (Cardio) Pulmonary Syndrome
☐ Non-pulmonary Hantavirus Disease

PATIENT'S BACKGROUND AND EXPOSURE INFORMATION

Occupation: _____

Race *(Check all that apply)*:
☐ American Indian/Alaska Native:
☐ Asian ☐ Black or African American
☐ White ☐ Native Hawaiian/other Pacific Islander

Ethnicity: _____

History of rodent exposure 8 weeks prior to illness onset? ☐ Yes ☐ No

If yes, type of rodent exposure: _____

Place of contact (town, county, state): _____

Exposure occurred while *(Check all that apply)*:

☐ Cleaning ☐ Working ☐ Recreational activity (camping, hiking) ☐ Other (explain below)

Additional information about exposure:

TIMELINE

Date symptom onset: _____

Was patient hospitalized? ☐ Yes ☐ No

Date of admission: _____

Date of discharge: _____

PRE-HOSPITAL TREATMENT

Did patient seek care before admission?
☐ Yes ☐ No

Date: _____

Outcome *(sent home, diagnosed as flu, etc)*:

CLINICAL INFORMATION

Fever > 101F (38.3C)? ☐ Yes ☐ No

Thrombocytopenia? (<150,000) ☐ Yes ☐ No

Elevated hematocrit? ☐ Yes ☐ No

Elevated creatinine? ☐ Yes ☐ No

HOSPITAL COURSE

Supplemental oxygen required? ☐ Yes ☐ No

Was patient on ECMO? ☐ Yes ☐ No

Was patient intubated? ☐ Yes ☐ No

CXR with unexplained bilateral interstitial infiltrates or suggestive of ARDS? ☐ Yes ☐ No

Notes on clinical course of illness:

OUTCOME

Outcome of illness: _____

Date of death: _____

Autopsy performed? ☐ Yes ☐ No

Autopsy findings:

TESTING INFORMATION

Type of specimen collected: _____

Date of collection: _____

Lab performing test: _____

Type of test: _____

Results: _____

FOR STATE HEALTH DEPARTMENTS

State Health Department reporting case: _____ State/local ID no.: _____ Date form completed: 01/24/2018

Person completing Report: _____ Email: _____ Phone number: _____

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

CDC 56.60 (E), January 2018, CDC Adobe Acrobat DC, S508 Electronic Version, January 2018

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. Acknowledgment of receipt by CDC is not provided.

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