Case ID: _______________________

**Reporting and Follow-up Information**

1. Date case was reported to the state health department _______/ _______/ ________ (mm/dd/yyyy)
2. Date case report form initiated _______/ _______/ ________ (mm/dd/yyyy)
3. Name of person completing form________________________________________________________
4. Person reporting case to health department:
   Name and Position: ____________________________________________________________________________
   Institution: ___________________________________________ Street address: ____________________________________________
   City: _________________________________________________ State/Country: ________________________ Zip: _____________
   Phone: _____________________________________________ Pager: ____________________________________________
   Fax: _____________________________________________ Email: ____________________________________________

5. Other epi/medical contacts (include health departments, clinicians, laboratorians, medical records staff)
   Name and Position Contact numbers
   a. ___________________________________________________________ ___________________________________________________________
   b. ___________________________________________________________ ___________________________________________________________
   c. ___________________________________________________________ ___________________________________________________________
   d. ___________________________________________________________ ___________________________________________________________
   e. ___________________________________________________________ ___________________________________________________________

6. Facilities where patient received medical care for current illness
   Hospital/ Clinic Name Patient or Medical Record Admission/ Visit Date
   a. ___________________________________________________ _______________________________ _______/ _______/ ________
   b. ___________________________________________________ _______________________________ _______/ _______/ ________
   c. ___________________________________________________ _______________________________ _______/ _______/ ________
   d. ___________________________________________________ _______________________________ _______/ _______/ ________
   e. ___________________________________________________ _______________________________ _______/ _______/ ________

7. Patient and family contacts
   Name and Relationship to Patient Contact numbers
   a. ___________________________________________________________ ___________________________________________________________
   b. ___________________________________________________________ ___________________________________________________________
   c. ___________________________________________________________ ___________________________________________________________
   d. ___________________________________________________________ ___________________________________________________________
   e. ___________________________________________________________ ___________________________________________________________

8. Permission from physician to contact patient or patient’s family ? Yes No
9. Permission from patient or patient’s family to recontact for followup? Yes No
10. Data sources used to complete form (Check all that apply) 
    Physician interview  Medical record review  Patient/patient’s family

11. Patient’s current status:  
   Died  Discharged to chronic care facility  
   Hospitalized, in ICU  Discharged home  
   Hospitalized, on ward  Never hospitalized

12. Diagnoses: ____________________________________________

---

(1 of 13) SAMPLE EXTENDED DATA COLLECTION INSTRUMENT  
LONG FORM  
Updated: Jan 2008  
U.S. Department Health & Human Services | Centers for Disease Control and Prevention
Demographic Information

1. Patient Name  
   First: ____________________________  Last: ____________________________

2. Age: ____________  Years/ Months/ Days (Circle One)

3. Date of birth: [mm/dd/yyyy] _______/ _______/ ________

4. Sex:  
   □ Male  □ Female

5. Race: check one  
   □ White  □ Black/African American  □ Asian  
   □ Hawaiian/Pacific Islander  □ American Indian/Native Alaskan  
   □ Unknown  □ Other, specify: ________________________

6. Ethnicity:  
   □ Hispanic or Latino  □ Not Hispanic or Latino  □ Unknown

7. Was the patient born in the United States?  
   □ Yes  □ No  □ Unknown

   If NO, Country of birth: ______________________________  Year emigrated to U.S. ________

8. Place of residence:  
   Street address: ______________________________________

   City: __________________________  State: __________________________  Zip: _______________________

   County: ______________________  Country: ______________________

   Phone #: (_______) ________ - _______________  Phone2 #: (_______) ________ - _______________

9. Does patient live in an institutional setting?  
   □ Yes  □ No  □ Unknown

   If YES, Name of facility: ______________________________  Room number: ________

   Type of facility:  
   □ Nursing home/long-term care facility  □ Jail/prison

   □ Residential program/treatment facility  □ Other: _______________________

   □ Shelter

10. Date of illness onset: _______/ _______/ ________ (mm/dd/yyyy)

11. Was the patient evaluated by a physician for this illness?  
   □ Yes  □ No  □ Unknown

12. Was the patient evaluated at an emergency room for this illness?  
   □ Yes  □ No  □ Unknown

13. Was the patient hospitalized for this illness?  
   □ Yes  □ No  □ Unknown

   If YES, Date first hospitalized _______/ _______/ ________ (mm/dd/yyyy)

14. If hospitalized, has the patient been discharged?  
   □ Yes  □ No  □ Unknown

   If YES, Date discharged _______/ _______/ ________ (mm/dd/yyyy)

Occupation

In the ONE MONTH PRIOR to illness onset (unless otherwise noted), did the patient:

1. Work outside of the home?  
   □ Yes  □ No  □ Unknown

   If YES, Occupation: ______________________________________

   Company name: ______________________________________

   Describe activities: _____________________________________

   If YES, In a healthcare setting (e.g doctor’s office, hospital, nursing home, lab)?  
   □ Yes  □ No  □ Unknown

2. Attend school or day care?  
   □ Yes  □ No  □ Unknown

   If YES, Name of school or day care: ______________________

3. Have children in day care?  
   □ Yes  □ No  □ Unknown

   If YES, Name of school or day care: ______________________
## Exposures to Respiratory Illness

In the ONE MONTH PRIOR to illness onset (unless otherwise noted), did/was the patient:

1. Have contact with anyone with a respiratory illness?  
   - Yes  
   - No  
   - Unknown
   
   If YES, Type of contact (check all that apply):  
   - Household/Intimate  
   - Institutional setting  
   - Healthcare setting  
   - Other, specify: _______________________

   If YES, dates of exposure: First date: _______/ _______/ ________  Last date: _______/ _______/ ________

2. Admitted to the hospital for another illness/condition?  
   - Yes  
   - No  
   - Unknown

   If YES, Date admitted: _______/ _______/ ________  Date discharged: _______/ _______/ ________

Describe reason for hospitalization: _____________________________________

## Travel History (within past 8 weeks)

1. Travel outside of the United States?  
   - Yes  
   - No  
   - Unknown

   If YES, List countries: ________________________________________________________________________

2. Travel within the U.S but outside of his/her home state?  
   - Yes  
   - No  
   - Unknown

   If YES, List states: ________________________________________________________________________

## Recreational activities (within past 8 weeks)

1. Garden, excavate or work with soil?  
   - Yes  
   - No  
   - Unknown

2. Spent time in an infrequently used structure/space (e.g. attic or cabin)?  
   - Yes  
   - No  
   - Unknown

3. Perform construction or renovations?  
   - Yes  
   - No  
   - Unknown

4. Mow grass or hay?  
   - Yes  
   - No  
   - Unknown

5. Go hiking or camping?  
   - Yes  
   - No  
   - Unknown

6. Explore caves?  
   - Yes  
   - No  
   - Unknown

7. Have water exposures (e.g. fishing, boating, swimming, hot tub)?  
   - Yes  
   - No  
   - Unknown

   If YES, Type of water:  
   - Pool  
   - Saltwater (e.g. ocean)  
   - Freshwater (e.g. lake, river, stream)  
   - Other: _______________________

## Animal Exposures (within past 8 weeks)

1. Have animals living in his/her home (including pets)?  
   - Yes  
   - No  
   - Unknown

2. Receive an animal bite (including wild and domestic animals)?  
   - Yes  
   - No  
   - Unknown

3. Receive an insect bite (e.g. mosquito, tick, spider)?  
   - Yes  
   - No  
   - Unknown

4. Have close contact with rodents (e.g. rats, mice, squirrels, prairie dogs)?  
   - Yes  
   - No  
   - Unknown

5. Have close contact with rodent droppings or rodent nests?  
   - Yes  
   - No  
   - Unknown

6. Have close contact with birds (includes turkeys and chickens)?  
   - Yes  
   - No  
   - Unknown

7. Have close contact with bird droppings?  
   - Yes  
   - No  
   - Unknown

8. Have close contact with swine?  
   - Yes  
   - No  
   - Unknown

9. Go hunting or fishing?  
   - Yes  
   - No  
   - Unknown

10. Skin, dress, or eat wild game?  
    - Yes  
    - No  
    - Unknown

11. Spend time on a farm, rural area or petting zoo?  
    - Yes  
    - No  
    - Unknown

12. Perform or assist with an animal necropsy?  
    - Yes  
    - No  
    - Unknown

13. Have close contact with animals in any other setting?  
    - Yes  
    - No  
    - Unknown

   If the patient answered YES to any of the above questions, list animal(s)/insect(s), and type of exposure

<table>
<thead>
<tr>
<th>Animal/Insect</th>
<th>Type of exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>_______</td>
<td>_______</td>
</tr>
</tbody>
</table>

   a. _______________________
   b. _______________________
   c. _______________________
   d. _______________________

(3 of 13) SAMPLE EXTENDED DATA COLLECTION INSTRUMENT
LONG FORM

U.S. Department Health & Human Services | Centers for Disease Control and Prevention

Updated: Jan 2008
**Medications/Biologicals**

In the ONE MONTH PRIOR to illness onset (unless otherwise noted), did/was the patient:

1. Receive any immunizations?  
   - Yes  ☐  No  ☐  Unknown  ☐  
   - If YES, List vaccines:________________________________________________________

2. Receive an influenza vaccine THIS SEASON?  
   - Yes  ☐  No  ☐  Unknown  ☐  
   - If yes, date of last vaccination: ____/____/_____

3. Take any medications including prescription, over the counter, or herbal remedies?  
   - Yes  ☐  No  ☐  Unknown  ☐  
   - If YES, List medications:________________________________________________________

**Other exposures**

1. Smoke cigarettes?  
   - Yes  ☐  No  ☐  Unknown  ☐  
2. Work with any chemicals or toxins?  
   - Yes  ☐  No  ☐  Unknown  ☐  
   - If YES, Specify:________________________________________________________

3. Have any other significant exposures?  
   - Yes  ☐  No  ☐  Unknown  ☐  
   - If YES, Describe:________________________________________________________

**Past Medical History**

Prior to his/her recent illness, had the patient ever been diagnosed with any of the following conditions:

1. AIDS/HIV-positive?  
   - Yes  ☐  No  ☐  Unknown  ☐  
2. Any other immune compromising conditions/medications (e.g. steroids, chemotherapy)?  
   - Yes  ☐  No  ☐  Unknown  ☐  
   - If YES, Condition/Medication(s): _____________________________________________

3. Bone marrow or solid organ transplant?  
   - Yes  ☐  No  ☐  Unknown  ☐  
4. Asplenia (no spleen)?  
   - Yes  ☐  No  ☐  Unknown  ☐  
5. Autoimmune disease, such as lupus?  
   - Yes  ☐  No  ☐  Unknown  ☐  
   - If YES, Type of disease: ________________________________________________

6. Cancer/malignancy?  
   - Yes  ☐  No  ☐  Unknown  ☐  
   - If YES, Type of cancer: __________________________  Year diagnosed: __________

7. Indwelling catheter?  
   - Yes  ☐  No  ☐  Unknown  ☐  
8. Chronic lung disease?  
   - Yes  ☐  No  ☐  Unknown  ☐  
9. Asthma?  
   - Yes  ☐  No  ☐  Unknown  ☐  
10. Active tuberculosis or positive PPD?  
    - Yes  ☐  No  ☐  Unknown  ☐  
11. Heart disease?  
    - Yes  ☐  No  ☐  Unknown  ☐  
12. High blood pressure (hypertension)?  
    - Yes  ☐  No  ☐  Unknown  ☐  
13. Stroke?  
    - Yes  ☐  No  ☐  Unknown  ☐  
14. Deep venous thrombosis or coagulopathy?  
    - Yes  ☐  No  ☐  Unknown  ☐  
15. Sickle cell disease/thalassemia/hemoglobinopathy?  
    - Yes  ☐  No  ☐  Unknown  ☐  
16. Diabetes mellitus?  
    - Yes  ☐  No  ☐  Unknown  ☐  
17. Goiter or thyroid disease?  
    - Yes  ☐  No  ☐  Unknown  ☐  
18. Renal insufficiency or failure?  
    - Yes  ☐  No  ☐  Unknown  ☐  
    - If YES, On dialysis  
19. Chronic hepatitis or liver disease?  
    - Yes  ☐  No  ☐  Unknown  ☐  
20. Any other significant conditions?  
    - Yes  ☐  No  ☐  Unknown  ☐  
    - If YES, Specify:________________________________________________________
### Review of Symptoms

As part of this illness, has the patient had any of the following symptoms:

1. Fever?  
2. Sweats?  
3. Chills/rigors?  
4. Cough?  
   - If YES, with sputum production?  
   - If YES, bloody sputum/hemoptysis?  
5. Wheezing?  
6. Shortness of breath/difficulty breathing?  
7. Chest pain?  
8. Runny nose?  
9. Sore throat?  
10. Difficulty swallowing?  
11. Ear pain?  
12. Red or draining eyes?  
13. Muscle aches?  
14. Joint pain/swelling?  
15. Enlarged/swollen glands?  
16. Rash?  
17. Stiff neck?  
18. Seizures?  
19. Vomiting?  
   - If YES, with blood?  
20. Diarrhea?  
   - If YES, with blood?  
21. Dark or bloody urine?  
22. Yellow skin/eyes (jaundice)?  
23. Any other significant symptoms?  
   - If YES, Describe, including dates of onset:  
24. Date of symptom resolution: __/__/____

Date first noted: [mm/dd/yyyy]

Case ID:________________________
### Physical signs

As part of this illness, did the patient have any of the following signs on physical exam?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th>Date first noted: (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recorded temperature &gt;38.0°C (100.4°F)</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>If YES, max temperature recorded</td>
<td>C or F (circle one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First date max temperature was recorded</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last date patient had a fever &gt;38.0°C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Systolic blood pressure &lt;90 mm Hg</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>3. Room air oxygen saturation &lt;95%</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>4. Wheezes or rhonchi</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>5. Rales or crackles</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>6. Signs of respiratory distress</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>7. Adult respiratory rate (RR) =&gt;25</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>(Child &lt;5 years: RR &gt; 40)</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>(Infant: RR &gt; 50)</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>8. Arrhythmia</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>9. Lymphadenopathy</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>If YES, check all location(s):</td>
<td>Postauricular</td>
<td>Submandibular</td>
<td>Axillary</td>
</tr>
<tr>
<td></td>
<td>Cervical</td>
<td>Medialastinal</td>
<td></td>
</tr>
<tr>
<td>10. Rash</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>If YES, check all types noted:</td>
<td>Macules/papules</td>
<td>Vesicles/bullaes</td>
<td>Eschar</td>
</tr>
<tr>
<td></td>
<td>Petechiae/purpura</td>
<td>Ulcers/sores</td>
<td>Erythroderma</td>
</tr>
<tr>
<td>If YES, check all sites involved:</td>
<td>Head/neck</td>
<td>Trunk</td>
<td>Extremities</td>
</tr>
<tr>
<td>11. Mucosal lesions</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>12. Meningismus/ nuchal rigidity</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>13. Seizures</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>14. Altered mental status of &gt;24h duration</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>If YES, level of consciousness (check all that apply)</td>
<td>Confused</td>
<td>Lethargic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disoriented</td>
<td>Agitated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drowsy</td>
<td>Comatose</td>
<td></td>
</tr>
<tr>
<td>15. Focal neurologic abnormality</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>If YES, describe:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Hepatosplenomegaly</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>17. Jaundice/ icterus</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>18. Any other significant physical findings</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>If YES, Describe, including dates first noted:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Case ID: __________________________
Imaging studies

At any point during this acute illness, did the patient receive any of the following imaging studies?

1. Chest x-ray or CT scan:  
   - Yes  
   - No  
   - Unknown
   
   If YES, Date first performed: ______/______/______  
   Overall impression:  
   - Normal  
   - Abnormal  
   - Unknown
   
   If abnormal findings, check all that apply:
   - Single lobar infiltrate
   - Pleural effusion
   - Pneumomediastium
   - Enlarged heart
   - Multi-lobar infiltrate
   - Hilar adenopathy
   - Widened mediastinum
   - Enlarged trachea
   - Complete opacification
   - Granuloma
   - Pulmonary cavity or blebs
   - Enlarged epiglottis
   - Interstitial infiltrate
   - Pneumothorax
   - Empyema

   Check all alveolar spaces with any abnormality:
   - Left upper lobe
   - Left lower lobe
   - Right middle lobe
   - Left lingula
   - Right upper lobe
   - Right lower lobe

   Summarize findings:

2. Another chest x-ray or CT scan with significantly different findings:  
   - Yes  
   - No  
   - Unknown
   
   If YES, Date performed: ______/______/______  
   Overall impression:  
   - Normal  
   - Abnormal  
   - Unknown
   
   If abnormal findings, check all that apply:
   - Single lobar infiltrate
   - Pleural effusion
   - Pneumomediastium
   - Enlarged heart
   - Multi-lobar infiltrate
   - Hilar adenopathy
   - Widened mediastinum
   - Enlarged trachea
   - Complete opacification
   - Granuloma
   - Pulmonary cavity or blebs
   - Enlarged epiglottis
   - Interstitial infiltrate
   - Pneumothorax
   - Empyema

   Check all alveolar spaces with any abnormality:
   - Left upper lobe
   - Left lower lobe
   - Right middle lobe
   - Left lingula
   - Right upper lobe
   - Right lower lobe

   Summarize findings:

3. Cardiac catheterization or echocardiogram:  
   - Yes  
   - No  
   - Unknown
   
   If YES, Date performed: ______/______/______  
   Ejection fraction: ________ %
   Overall impression:  
   - Normal  
   - Abnormal  
   - Unknown

   Summarize findings:

4. Other imaging study:  
   - Yes  
   - No  
   - Unknown
   
   If YES, Type of imaging study: _____________

   If YES, Date performed: ______/______/______

   Site imaged:
   - Head
   - Abdomen
   - Chest
   - Pelvis
   Other: _____________

   Overall impression:  
   - Normal  
   - Abnormal  
   - Unknown

   Summarize findings:
Hematology and Serum Chemistries

For the following tests, please list the initial values and any additional values if results changed significantly:

<table>
<thead>
<tr>
<th>Test</th>
<th>First recorded</th>
<th>Other significant values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date 1:</td>
<td>Date 2:</td>
</tr>
<tr>
<td>White blood cell count (WBC)</td>
<td>_______ cells/mm³</td>
<td>_______ cells/mm³</td>
</tr>
<tr>
<td>Differential for WBC above:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neutrophils:</td>
<td>_______ %</td>
<td>_______ %</td>
</tr>
<tr>
<td>Bands:</td>
<td>_______ %</td>
<td>_______ %</td>
</tr>
<tr>
<td>Lymphocytes:</td>
<td>_______ %</td>
<td>_______ %</td>
</tr>
<tr>
<td>Eosinophils:</td>
<td>_______ %</td>
<td>_______ %</td>
</tr>
<tr>
<td>Hematocrit (Hct)</td>
<td>_______ %</td>
<td>_______ %</td>
</tr>
<tr>
<td>Platelets (Plt)</td>
<td>_______ 10³/mm³</td>
<td>_______ 10³/mm³</td>
</tr>
<tr>
<td>Prothrombin time (PT)</td>
<td>_______ sec</td>
<td>_______ sec</td>
</tr>
<tr>
<td>INR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sodium (Na)</td>
<td>_______ mEq/L</td>
<td>_______ mEq/L</td>
</tr>
<tr>
<td>Potassium (K)</td>
<td>_______ mEq/L</td>
<td>_______ mEq/L</td>
</tr>
<tr>
<td>Chloride (Cl)</td>
<td>_______ mEq/L</td>
<td>_______ mEq/L</td>
</tr>
<tr>
<td>Bicarbonate (HCO₃⁻)</td>
<td>_______ mEq/L</td>
<td>_______ mEq/L</td>
</tr>
<tr>
<td>Calcium</td>
<td>_______ mEq/L</td>
<td>_______ mEq/L</td>
</tr>
<tr>
<td>Creatinine</td>
<td>_______ mg/dL</td>
<td>_______ mg/dL</td>
</tr>
<tr>
<td>Blood urea nitrogen (BUN)</td>
<td>_______ mg/dL</td>
<td>_______ mg/dL</td>
</tr>
<tr>
<td>Glucose</td>
<td>_______ mg/dL</td>
<td>_______ mg/dL</td>
</tr>
<tr>
<td>SGPT/ALT</td>
<td>_______ U/L</td>
<td>_______ U/L</td>
</tr>
<tr>
<td>SGOT/AST</td>
<td>_______ U/L</td>
<td>_______ U/L</td>
</tr>
<tr>
<td>Total bilirubin</td>
<td>_______ mg/dL</td>
<td>_______ mg/dL</td>
</tr>
<tr>
<td>Serum ammonia</td>
<td>_______ mcg/dL</td>
<td>_______ mcg/dL</td>
</tr>
<tr>
<td>Alkaline phosphatase</td>
<td>_______ U/L</td>
<td>_______ U/L</td>
</tr>
<tr>
<td>Lactate dehydrogenase [LDH]</td>
<td>_______ U/L</td>
<td>_______ U/L</td>
</tr>
<tr>
<td>Lipase</td>
<td>_______ U/L</td>
<td>_______ U/L</td>
</tr>
<tr>
<td>Creatine kinase (CK or CPK)</td>
<td>_______ U/L</td>
<td>_______ U/L</td>
</tr>
<tr>
<td>C-Reactive protein [CRP]</td>
<td>_______ mg/dL</td>
<td>_______ mg/dL</td>
</tr>
<tr>
<td>Erythrocyte sed rate [ESR]</td>
<td>_______ mm/hr</td>
<td>_______ mm/hr</td>
</tr>
<tr>
<td>Albumin</td>
<td>_______ gl/dL</td>
<td>_______ gl/dL</td>
</tr>
</tbody>
</table>
Medications and Blood Products

At any point during this acute illness, did the patient receive any of the following?

1. Antimicrobials (include antibacterial, antiviral, and antifungal agents):
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

2. Immune modulating, immune suppressive or anti-inflammatory agents (e.g. steroids, azathioprine, methotrexate):
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

3. Any other medications after symptom onset, including acetaminophen, ibuprofen or other over the counter medications:
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

   If YES to any of questions 1-3, please complete the following information for each agent received:

<table>
<thead>
<tr>
<th>Name of the agent</th>
<th>Date 1st received</th>
<th>Date last received</th>
<th>Route of administration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong><strong>/</strong></strong>/____</td>
<td><strong><strong>/</strong></strong>/____</td>
<td>PO</td>
</tr>
<tr>
<td></td>
<td><strong><strong>/</strong></strong>/____</td>
<td><strong><strong>/</strong></strong>/____</td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td><strong><strong>/</strong></strong>/____</td>
<td><strong><strong>/</strong></strong>/____</td>
<td>IM</td>
</tr>
<tr>
<td></td>
<td><strong><strong>/</strong></strong>/____</td>
<td><strong><strong>/</strong></strong>/____</td>
<td>Other</td>
</tr>
</tbody>
</table>

4. Blood products:
   - [ ] Whole blood
   - [ ] Platelets
   - [ ] Immunoglobulins/IVIG
   - [ ] Cryoprecipitate
   - [ ] Fresh frozen plasma
   - [ ] Packed red blood cells (pRBCs)

   If YES, Check types of products received:

   Date 1st received any blood product: _____/_____/____

Severity and Outcomes of illness

At any time during the current illness, did the patient require or have?

1. Admission to intensive care unit:
   - [ ] Yes
   - [ ] No
   - [ ] Unknown
   - If YES, Date admitted: _____/_____/_____  Date discharged (if applicable): _____/_____/_____  

2. Supplemental oxygen:
   - [ ] Yes
   - [ ] No
   - [ ] Unknown
   - If YES, Date started: _____/_____/_____  Date stopped: _____/_____/_____  

3. Vasopressor medications (e.g. dopamine, epinephrine):
   - [ ] Yes
   - [ ] No
   - [ ] Unknown
   - If YES, Date started: _____/_____/_____  Date stopped: _____/_____/_____  

4. Mechanical ventilation:
   - [ ] Yes
   - [ ] No
   - [ ] Unknown
   - If YES, Date started: _____/_____/_____  Date stopped: _____/_____/_____  

5. Cardiopulmonary arrest:
   - [ ] Yes
   - [ ] No
   - [ ] Unknown
   - If YES, Date: _____/_____/_____  

6. Did the patient die?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown
   - If YES, Date: _____/_____/_____  

7. If the patient died, was an autopsy performed?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown
   - If YES, Date: _____/_____/_____  

Summarize findings:
____________________________________________________________________________________________________________________________

(9 of 13)  SAMPLE EXTENDED DATA COLLECTION INSTRUMENT  LONG FORM  Updated: Jan 2008
U.S. Department Health & Human Services | Centers for Disease Control and Prevention
If any sterile site fluids were obtained, please note the following results

<table>
<thead>
<tr>
<th>Specimen type*</th>
<th>Date collected</th>
<th>Protein (mg/dl)</th>
<th>Glucose (mg/dl)</th>
<th>RBCs (cells/mm³)</th>
<th>WBCs (cells/mm³)</th>
<th>Polys (%)</th>
<th>Lymphs (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Specimen type: Bronchoalveolar lavage (BAL), cerebrospinal fluid (CSF), pericardial fluid, peritoneal fluid, pleural fluid, synovial fluid, urine
### Culture results

<table>
<thead>
<tr>
<th>Specimen type*</th>
<th>Date</th>
<th>Culture type (Check one)</th>
<th>Result (Check one)</th>
<th>If positive:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Bacterial</td>
<td>Viral</td>
<td>Fungal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Specimen type: Blood, bronchoalveolar lavage (BAL), cerebrospinal fluid (CSF), nasopharyngeal swab/aspirate, pericardial fluid, peritoneal fluid, pleural fluid, sputum, synovial fluid, tissue (specify site), throat/oropharyngeal swab, stool or urine"
<table>
<thead>
<tr>
<th>Specimen type*</th>
<th>Date</th>
<th>Test performed</th>
<th>Results</th>
<th>Interpretation (circle one)</th>
<th>Laboratory notes (if present)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Indeterminate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Indeterminate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Indeterminate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Indeterminate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Indeterminate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Indeterminate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Indeterminate</td>
<td></td>
</tr>
</tbody>
</table>

*Specimen type: Blood, bronchoalveolar lavage (BAL), cerebrospinal fluid (CSF), nasopharyngeal swab/aspirate, pericardial fluid, peritoneal fluid, pleural fluid, acute serum, convalescent serum, paired sera, sputum, synovial fluid, tissue (specify site), throat/oropharyngeal swab, stool or urine
<table>
<thead>
<tr>
<th>Tissue Type*</th>
<th>Biopsy tissue?</th>
<th>Abnormal findings?</th>
<th>Findings Comments (Check all that apply)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Inflammation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>Edema</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Hemorrhage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>Fibrosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Necrosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>Granuloma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Edema</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>Granuloma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Hemorrhage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>Fibrosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Necrosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>Cirrhosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Edema</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>Granuloma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Hemorrhage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>Fibrosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Necrosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>Cirrhosis</td>
<td></td>
</tr>
</tbody>
</table>
| *Tissue type, ex: Adrenal, bone marrow, brain, spinal cord, heart, kidney, liver, lung, lymph node, muscle, skin, spleen, etc