

## HANTAVIRUS PULMONARY SYNDROME SCREENING FORM

Name of person completing form: \_\_\_\_\_ Today's date: \_\_\_\_\_  
 Report source: \_\_\_\_\_ Agency: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Email address: \_\_\_\_\_

Patient Name-Last	First	Middle Initial	Date of birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Address- Number, Street, Apt #		City	State	ZIP Code	
Telephone number Home (____) _____		Work (____) _____		Cell (____) _____	
Race (check one) <input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Other: _____ If Native American, Name of tribe. _____			Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino		

**PRESENT ILLNESS**

Onset date	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital name	Medical record no.	Admit date	Discharge date
Transferred to /from another hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Hospital name: _____					
Medical record no. _____		Admit date: : ____ / ____ / ____		Discharge date: : ____ / ____ / ____	

Symptoms (check all that apply): <input type="checkbox"/> Fever ( $\geq 101^\circ$ F/ $38^\circ$ C): Highest _____ <input type="checkbox"/> Cough <input type="checkbox"/> Vomiting <input type="checkbox"/> Malaise <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Myalgia <input type="checkbox"/> Headache <input type="checkbox"/> Diarrhea <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Other: Specify. _____	Outcome? <input type="checkbox"/> Died <input type="checkbox"/> Recovered <input type="checkbox"/> Unknown If Died, Date died: ____ / ____ / ____ Was an autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Was autopsy compatible with non-cardiogenic pulmonary edema? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Did the patient require supplemental oxygen?  Yes  No

Did the patient have an O<sub>2</sub> saturation <90%?  Yes  No

Was the patient intubated?  Yes  No

Did the patient have bilateral intestinal pulmonary infiltrates?  Yes  No If Yes, Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Did the patient develop ARDS within one week of admission?  Yes  No If Yes, Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Was the patient on ribavirin?  Yes  No

**RULING OUT HANTAVIRUS (If patient meets any of the following criteria, they do not meet the surveillance case definition.)**

Did the patient have a history of the following?

Oxygen dependent chronic obstructive pulmonary disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Solid tumors or hematologic malignancies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital or acquired immunodeficiency disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical conditions or organ transplant requiring immunosuppressive therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No

Does the patient have an acute illness that is likely to explain the respiratory illness?

Recent major trauma, burn, or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent seizures or history of aspiration	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bacterial sepsis or serologic evidence of another respiratory disorder (legionella, influenza, mycoplasma, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Acute pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No

Patient name (last, first) \_\_\_\_\_ Date of Birth \_\_\_\_\_

**LABORATORY VALUES**

<input type="checkbox"/> Thrombocytopenia (platelets <150,000): Lowest _____		<input type="checkbox"/> Elevated hematocrit: Highest hematocrit _____	
WBC:	Total neutrophils: _____%	Banded neutrophils: _____%	Lymphocytes: _____%
Hantavirus serology results:	Date of collection: : ____ / ____ / ____		Laboratory:
Hantavirus serum antibody:	IgM:	IgG:	Combined or unspecified:
Sin Nombre Virus antibody:	IgM:	IgG:	

**RODENT EXPOSURE**

History of rodent exposure in the 6 weeks before onset of illness/symptoms?  Yes  No  
If Yes, Place of contact. \_\_\_\_\_ Date of exposure : \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Type of rodent. \_\_\_\_\_

**INITIAL IMPRESSION (refer to B-73 for case definitions)**

NOT CASE  SUSPECT CASE  CONFIRMED CASE

**REMARKS**