

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
Ethnicity: _____ White Native Hawaiian/other Pacific Islander

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: _____

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:

PRE-HOSPITAL TREATMENT

Did patient seek care before admission?

Yes No

Date: _____

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

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: _____

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

Name of patient's physician: _____ Email: _____ 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. Acknowledgment of receipt by CDC is not provided.