



Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Infection

County _____

Case name (last, first) _____
 Birth date ___/___/___ Age at symptom onset _____ Years Months
 Alternate name _____
 Phone _____ Email _____
 Address type Home Mailing Other Temporary Work
 Street address _____
 City/State/Zip/County _____
 Residence type (incl. Homeless) _____ WA resident Yes No

ADMINISTRATIVE

Investigator _____ LHM Case ID (optional) _____

LHM notification date ___/___/___

Classification
 Classification pending Confirmed Investigation in progress Not reportable Probable Ruled out Suspect
 Investigation status
 Complete Complete – not reportable to DOH Unable to complete Reason _____ In progress
 Dates: **Investigation start** ___/___/___ Investigation complete ___/___/___ Record complete ___/___/___ **Case complete** ___/___/___

REPORT SOURCE

Initial report source _____ LHM _____
 Reporter organization _____
 Reporter name _____ Reporter phone _____
 All reporting sources (list all that apply) _____

DEMOGRAPHICS

Sex at birth: Female Male Other Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?
Ethnicity Hispanic, Latino/a, Latinx Non-Hispanic, Latino/a, Latinx Patient declined to respond Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):
Race Amer Ind/AK Native (**specify:** Amer Ind **and/or** AK Native) Asian Black or African American
 Native HI/Pacific Islander (**specify:** Native HI **and/or** Pacific Islander) White Patient declined to respond Unk

Additional race information:
 Afghan Afro-Caribbean Arab Asian Indian Bamar/Burman/Burmese Bangladeshi Bhutanese
 Central American Cham Chicano/a or Chicanx Chinese Congolese Cuban Dominican Egyptian
 Eritrean Ethiopian Fijian Filipino First Nations Guamanian or Chamorro Hmong/Mong
 Indigenous-Latino/a or Indigenous-Latinx Indonesian Iranian Iraqi Japanese Jordanian Karen
 Kenyan Khmer/Cambodian Korean Kuwaiti Lao Lebanese Malaysian Marshallese Mestizo
 Mexican/Mexican American Middle Eastern Mien Moroccan Nepalese North African Oromo
 Pakistani Puerto Rican Romanian/Rumanian Russian Samoan Saudi Arabian Somali
 South African South American Syrian Taiwanese Thai Tongan Ugandan Ukrainian
 Vietnamese Yemeni Other: _____

What is your (your child's) preferred language? Check one:
 Amharic Arabic Balochi/Baluchi Burmese Cantonese Chinese (unspecified) Chamorro Chuukese
 Dari English Farsi/Persian Fijian Filipino/Pilipino French German Hindi Hmong Japanese
 Karen Khmer/Cambodian Kinyarwanda Korean Kosraean Lao Mandarin Marshallese Mixteco
 Nepali Oromo Panjabi/Punjabi Pashto Portuguese Romanian/Rumanian Russian Samoan
 Sign languages Somali Spanish/Castilian Swahili/Kiswahili Tagalog Tamil Telugu Thai Tigrinya
 Ukrainian Urdu Vietnamese Other language: _____ Patient declined to respond Unknown

Interpreter needed Yes No Unk

EMPLOYMENT AND SCHOOL

Employed Yes No Unk Occupation _____ Industry _____
 Employer _____ Work site _____ City _____

Student/Day care Yes No Unk
 Type of school Preschool/day care K-12 College Graduate School Vocational Online Other
 School name _____ School address _____
 City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____
 OK to talk to patient (If Later, provide date) Yes Later ___/___/___ Never
 Date of interview attempt ___/___/___ Complete Partial Unable to reach Patient could not be interviewed
 Alternate contact: Parent/Guardian Spouse/Partner Friend Other _____
 Name _____ Phone _____
 Outbreak related Yes No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION (Note: enter as WDRS Rare Disease with minimal information, submit form to CDEpi fax 364-1060)

Onset date: ___/___/___ Derived Diagnosis date: ___/___/___ Illness duration: ___days

Signs and Symptoms

Y N Unk
 Fever Highest measured temperature (°F): _____
 Chills
 Dry cough Onset date ___/___/___
 Productive cough Onset date ___/___/___
 Shortness of breath
 Runny nose
 Sore throat
 Diarrhea
 Vomiting
 Abdominal pain
 Headache
 Muscle aches
 Other: _____

Clinical Findings

Y N Unk
 Pneumonia clinically diagnosed
 Pneumonia on x-ray, CT, or MIR
 Acute respiratory distress syndrome (ARDS)
 Kidney failure
 Admitted to intensive care
 Mechanical ventilation
 Treated with antiviral medications
 Type 1, dose: _____ Dates started: ___/___/___ stopped: ___/___/___
 Type 2, dose: _____ Dates started: ___/___/___ stopped: ___/___/___

Predisposing Conditions

Y N Unk
 Any current conditions such as:
 Smoker Cancer in the past year Chemotherapy Chronic heart disease Chronic lung disease
 Chronic kidney disease Chronic liver disease Diabetes Hemoglobinopathy
 Immunocompromised Organ transplant Obesity Height _____ (inches) Weight _____ (pounds)
 Other _____
 Pregnant If yes, weeks: _____ Pregnancy outcome: _____

Hospitalization

Y N Unk
 Hospitalized at least overnight for this illness Facility name _____
 Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
 Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
 Mechanical ventilation or intubation required
 Still hospitalized As of ___/___/___

Y N Unk

- Died of this illness** Death date ___/___/___ Please fill in the death date information on the Person Screen
- Healthcare visit prior to death
- Autopsy performed
- Death certificate lists disease as a cause of death or a significant contributing condition

RISK AND RESPONSE (Ask about exposures 1-14 days before symptom onset.)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____		
Start and end dates	_____/_____/_____ to ____/____/____	_____/_____/_____ to ____/____/____	_____/_____/_____ to ____/____/____

Risk and Exposure Information

Y N Unk

- Travel to an area with confirmed MERS** (Arabian Peninsula or neighboring countries or other area with outbreak)
 Countries: _____
- Others in household; if yes, total including case: _____
- Contact with a symptomatic traveler returning from Arabian Peninsula or neighboring countries
 Countries of travel: _____
- Contact with pneumonia or influenza-like illness
- Healthcare worker
- Healthcare setting exposure As: Healthcare worker Lab work Patient
 Setting: Hospital ER/ED Outpatient Long term care Other _____
- US military
- Air flight crew
- Congregate living or employment
 Barracks Corrections Long term care Dormitory Boarding school Camp Shelter
 Other _____
- Animal exposure
 Rat Cow Goat Camel Sheep Cat Other _____
 Description and location of contact (e.g., farm): _____
- No risk factors or likely exposures could be identified

Exposure and Transmission Summary

Y N Unk

- No risk factors or exposures could be identified**
- Likely geographic region of exposure** In Washington – county _____ Other state _____
 Not in US - country _____ Unk
- International travel related** During entire exposure period During part of exposure period No international travel
- Suspected exposure type Vectorborne Sexual Blood products Unk Other _____
 Describe _____

Exposure details:

Public Health Issues

Y N Unk

- Nosocomial infection suspected
- Work or volunteer in healthcare setting during contagious period Facility name _____
- Close contact works in healthcare setting
- Surgical masks used by personnel during transport
- Healthcare staff used personal protective equipment: Gloves Gowns Eye protection
 N95 or higher respirator Facemask Unknown
- If hospitalized:
 Negative pressure room
 Private room

Public Health Interventions/Actions**Y N Unk**

- Outbreak investigation
 Home isolation instructions given Date: ___/___/___
 Contact instructions given Number recommended for quarantine: _____
 Healthcare facility notified

NOTES**LAB RESULTS**Lab report information**Lab report reviewed – LHJ**

WDRS user-entered lab report note

Submitter _____

Performing lab for entire report _____

Referring lab _____

Specimen**Specimen identifier/accession number** _____**Specimen collection date** ___/___/___ **Specimen received date** ___/___/___**WDRS specimen type** _____

WDRS specimen source site _____

WDRS specimen reject reason _____

Test performed and result**WDRS test performed** _____**WDRS test result, coded** _____

WDRS test result, comparator _____

WDRS result, numeric only (enter only if given, including as necessary **Comparator** and **Unit of measure**) _____

WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

WDRS result summary Positive Negative Indeterminate Equivocal Test not performed PendingTest result status Final results; Can only be changed with a corrected result Preliminary results Record coming over is a correction and thus replaces a final result Results cannot be obtained for this observation Specimen in lab; results pending

Result date ___/___/___

Upload documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

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