Washington State Department of Health

# 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** _____ LHJ Case ID (optional)_____

**LHJ 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** _____ LHJ _____

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 childs) 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

Case Name _____ LHJ Case ID _____

## 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 (ºF): _____
☐ ☐ ☐ Chills
☐ ☐ ☐ **Dry cough** Onset date ___/___/____
☐ ☐ ☐ **Productive cough** Onset date ___/___/____
☐ ☐ ☐ Shortness of breath
☐ ☐ ☐ Runny nose
☐ ☐ ☐ Sore throat
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Vomit9ng
☐ ☐ ☐ 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 ling 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: | ☐ County/City _____<br>☐ State _____<br>☐ Country _____<br>☐ Other _____ | ☐ County/City _____<br>☐ State _____<br>☐ Country _____<br>☐ Other _____ | ☐ County/City _____<br>☐ State _____<br>☐ Country _____<br>☐ 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 ☐ Pending
Test 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 document**

Ordering Provider
WDRS ordering provider _____

Ordering facility
WDRS ordering facility name _____