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 (°F): _____________
☐ ☐ ☐ 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 ________ ☐ State ________ ☐ Country ________ ☐ Other ________	☐ County/City ________ ☐ State ________ ☐ Country ________ ☐ Other ________	☐ County/City ________ ☐ State ________ ☐ Country ________ ☐ 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 _________________________________

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