North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

North Carolina Public Health

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

SARS (CORONAVIRUS INFECTION)
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 71

ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease. Enter all information from this form into the NC EDSS question packages.

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

CLINICAL FINDINGS

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U

If yes, symptom onset date (mm/dd/yyyy): __/__/____

Fever ☐Y ☐N ☐U
- ☐ Yes, subjective ☐ No
- ☐ Yes, measured ☐ Unknown

Highest measured temperature_____

Fever onset date (mm/dd/yyyy):____/____/____

Sweats (diaphoresis) ☐Y ☐N ☐U

Cough ☐Y ☐N ☐U

Onset date (mm/dd/yyyy):____/____/____

Productive ☐Y ☐N ☐U

Describe (check all that apply)
- ☐ Clear
- ☐ Purulent
- ☐ Bloody (hemoptysis)

Shortness of breath/difficulty breathing/ respiratory distress ☐Y ☐N ☐U

Acute Respiratory Distress Syndrome (ARDS) ☐Y ☐N ☐U

Pathology consistent with respiratory distress syndrome ☐Y ☐N ☐U

Did the patient have a chest x-ray? ☐Y ☐N ☐U

Describe (check all that apply)
- ☐ Normal
- ☐ Infiltrate
- ☐ Diffuse infiltrates / findings suggestive of ARDS
- ☐ Pleural effusion
- ☐ Other

Pneumonia ☐Y ☐N ☐U

Confirmed by x-ray or CT ☐Y ☐N ☐U

Diarrhea ☐Y ☐N ☐U

Describe (select all that apply)
- ☐ Bloody
- ☐ Non-bloody
- ☐ Watery
- ☐ Other

Maximum number of stools in a 24-hour period:_____

Other symptoms, signs, clinical findings, or complications consistent with this illness ☐Y ☐N ☐U

Please specify:

REASON FOR TESTING

Why was the patient tested for this condition?
- ☐ Symptomatic of disease
- ☐ Screening of asymptomatic person with reported risk factor(s)
- ☐ Exposed to organism causing this disease (asymptomatic)
- ☐ Household / close contact to a person reported with this disease
- ☐ Other, specify_____
- ☐ Unknown

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐Y ☐N ☐U

Specify _____

_____

TREATMENT

Did the patient receive an antiviral for this illness? ☐Y ☐N ☐U

Specify antiviral name: _____

Date antiviral treatment began (mm/dd/yyyy):____/____/____

Time treatment began:_____ ☐AM ☐PM

Number of days taken:_____ ☐ Unknown

Did the patient require supplemental oxygen? ☐Y ☐N ☐U

Date started (mm/dd/yyyy):____/____/____

Did the patient require mechanical ventilation? ☐Y ☐N ☐U

Date started (mm/dd/yyyy):____/____/____

Number of days on mechanical ventilation:_____

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐Y ☐N ☐U

Hospital name: _____

City, State:_____

Hospital contact name: _____

Telephone: (_____) _____ - _____

Admit date (mm/dd/yyyy): ____/____/____

Discharge date (mm/dd/yyyy):____/____/____

ICU admission? ☐Y ☐N ☐U

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? ☐ Y ☐ N

Check all that apply:

☐ Work ☐ Sexual behavior
☐ Child care ☐ Blood and body fluid
☐ School ☐ Other, specify

_____

Date control measures issued: ____/____/____

Date control measures ended: ____/____/____

Was patient compliant with control measures? ☐ Y ☐ N

Local health director or designee implement additional control measures? ☐ Y ☐ N

If yes, specify: _____

_____

Were written isolation orders issued? ☐ Y ☐ N

If yes, where was the patient isolated? _____

_____

Date isolation started: ____/____/____

Date isolation ended: ____/____/____

Was the patient compliant with isolation? ☐ Y ☐ N

Were written quarantine orders issued? ☐ Y ☐ N

If yes, where was the patient quarantined?

_____

Date quarantine started: ____/____/____

Date quarantine ended: ____/____/____

Was the patient compliant with quarantine? ☐ Y ☐ N

TRAVEL & IMMIGRATION

The patient is:

☐ Resident of NC
☐ Resident of another state or US territory
☐ Foreign Visitor
☐ Refugee
☐ Recent Immigrant
☐ Foreign Adoptee
☐ None of the above

Did patient have a travel history during the 10 days prior to onset? ☐ Y ☐ N ☐ U

List travel dates and destinations:

From _____/_____/_____ to _____/_____/_____

_____

_____

Mode(s) of transportation (check all that apply)

☐ Airplane ☐ Train / subway
☐ Ship / boat / ferry ☐ On foot
☐ Automobile / motorcycle ☐ Bus/taxi/shuttle
☐ Other, specify: _____

Was patient pregnant while traveling? ☐ Y ☐ N ☐ U

If yes, was travel during the first trimester of pregnancy? ☐ Y ☐ N ☐ U

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐ Y ☐ N ☐ U

Name: _____

Did patient have contact with a person with travel history during the period of interest? ☐ Y ☐ N ☐ U

Contact's name: _____

Travel dates:

From: ____/____/____ until ____/____/____

To city: _____

To state: _____

To country: _____

BEHAVIORAL RISK & CONGREGATE LIVING

During the 10 days prior to onset of symptoms did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)**?** ☐ Y ☐ N ☐ U

Name of facility: _____

Dates of contact: _____

During the 10 days prior to onset, did the patient attend social gatherings or crowded settings? ☐ Y ☐ N ☐ U

If yes, specify: _____

In what setting was the patient most likely exposed?

☐ Restaurant
☐ Home
☐ Work
☐ Child Care
☐ School
☐ University / College
☐ Camp
☐ Doctor's office / Outpatient clinic
☐ Hospital In-patient
☐ Hospital Emergency Department
☐ Laboratory
☐ Long-term care facility / Rest Home
☐ Military
☐ Prison / Jail / Detention Center
☐ Place of Worship
☐ Outdoors, including woods or wilderness
☐ Athletics
☐ Farm
☐ Pool or spa
☐ Pond, lake, river or other body of water
☐ Hotel / motel
☐ Social gathering, other than listed above
☐ Travel conveyance (airplane, ship, etc.)
☐ International
☐ Community
☐ Other (specify) _____
☐ Unknown

Does the patient have any other risk for this disease? ☐ Y ☐ N ☐ U

Specify:

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

_____

Survived? ☐ Y ☐ N ☐ U

Died? ☐ Y ☐ N ☐ U

Died from this illness? ☐ Y ☐ N ☐ U

Date of death (mm/dd/yyyy): _____/_____/_____

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? ☐ Y ☐ N ☐ U

Patient a child care worker or volunteer in child care? ☐ Y ☐ N ☐ U

Patient a parent or primary caregiver of a child in child care? ☐ Y ☐ N ☐ U

Is patient a student? ☐ Y ☐ N ☐ U

Type of school:

Is patient a school WORKER / VOLUNTEER in NC school setting? ☐ Y ☐ N ☐ U

Give details:

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 10 days prior to onset of symptoms, did the patient have any of the following exposures:

☐ **Emergency Department (not hospitalized)** ..... ☐ Y ☐ N ☐ U
Facility name _____
City _____
State _____
Country _____

☐ **Hospitalized**
Visit / admit date (mm/dd/yyyy):____/____/____
Facility name _____
Has patient been discharged? ..... ☐ Y ☐ N ☐ U
Discharge date (mm/dd/yyyy):_____
Was facility notified regarding ill patient?
☐ Yes ☐ No ☐ Unknown ☐ Not applicable
Name of person notified _____
Date notified (mm/dd/yyyy):____/____/____

☐ **Long term care facility - resident (e.g. nursing home, rest home, rehab)**
Visit/admit date (mm/dd/yyyy):_____
Facility name _____
City _____ State _____
Country _____
Has patient been discharged? ..... ☐ Y ☐ N ☐ U
Discharge date (mm/dd/yyyy):____/____/____
Was facility notified regarding ill patient?
☐ Yes ☐ No ☐ Unknown ☐ Not applicable
Name of person notified _____
Date notified (mm/dd/yyyy):____/____/____

☐ **Outpatient facility - patient (e.g. urgent care, clinic, physician office)**
Visit / admit date (mm/dd/yyyy):____/____/____
Facility name _____
Has patient been discharged? ..... ☐ Y ☐ N ☐ U
Discharge date (mm/dd/yyyy):____/____/____
Was facility notified regarding ill patient?
☐ Yes ☐ No ☐ Unknown ☐ Not applicable
Name of person notified _____
Date notified (mm/dd/yyyy):____/____/____

☐ **Visitor to health care setting**
Facility name _____
City _____ State _____
Country _____

☐ **Worked or volunteered in health care or clinical setting**
Facility name _____
City _____ State _____
Country _____

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ..... ☐ Y ☐ N ☐ U
If yes, specify:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ..... ☐ Y ☐ N ☐ U
Date of interview (mm/dd/yyyy):_____/_____/_____

Were interviews conducted with others? ..... ☐ Y ☐ N ☐ U
Who was interviewed?

Were health care providers consulted? ..... ☐ Y ☐ N ☐ U
Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? ..... ☐ Y ☐ N ☐ U
Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?
Specify location:

☐ In NC
City _____
County _____

☐ Outside NC, but within US
City _____
State _____
County _____

☐ Outside US
City _____
Country _____

☐ Unknown

Is the patient part of an outbreak of this disease? ..... ☐ Y ☐ N

Notes:

SARS (coronavirus infection)

2003 CDC Case Definition

Refer to the Centers for Disease Control and Prevention (CDC) SARS web site for the surveillance case definition for SARS-CoV disease and other related information maintained by the National Center for Infectious Diseases (URL: www.cdc.gov/ncidod/sars/reporting.htm).

Note

Only cases of SARS-CoV disease are considered nationally notifiable. The SARS surveillance case definition also includes a non-specific case definition for "SARS reports under investigation." While States are encouraged to report both SARS reports under investigation and SARS-CoV disease, only SARS-CoV disease has been added to the national notifiable diseases list.

See also

SARS reports under investigation at URL: www.cdc.gov/ncidod/sars/reporting.htm.