

Hantavirus Supplemental Form

Kansas Department of Health

(Form Approved OMB 0920-0009)

Epidemiologic Case History

Case-patient Identification Number	FIPS-	Year-
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* indicates required fields

Case Type* <i>Human Case Non Human Case</i>	Classification* <i>Confirmed Not a Case Probable Suspect Deleted Unknown</i>
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Supplemental Form Status <i>Not Done Form Complete Form in Progress Form Approved Form Sent to CDC</i>
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Report Date* <small>mm/dd/yyyy</small>
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Transmit only lower portion if sent to CDC

Patient Demographic Information

* indicates required fields

Last Name*	First Name*	Middle Name	Name Type*	Age
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Age Unit <i>Days Weeks Months Years</i>	Date of Birth <small>mm/dd/yyyy</small>
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Race* <small>(Check all that apply)</small> <i>American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Unknown</i>
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Ethnicity* <i>Hispanic or Latino Not Hispanic or Latino Unknown</i>

Sex* <i>Failure to Report Female Male Other Transexual Unknown</i>

Street Address

City	State	Zip	Evening Phone <small>###-###-####</small>	Daytime Phone <small>###-###-####</small>
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Occupation

Person Providing Report

Last Name	First Name	Phone <small>###-###-####</small>	Name of Reporting Facility*
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Primary or Attending Physician

Title	Last Name	First Name	Phone
Ext.	Email	Physician Facility Name	Address
City	County	State	Zip

Hantavirus Pulmonary Syndrome Case Form

Hospital Information

Onset date <small>mm/dd/yyyy</small>	Was patient hospitalized? <i>Yes No Unknown</i>	Number of times hospitalized since onset of illness
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First Hospitalization

Name of hospital	Hospital address	Admission Date <small>mm/dd/yyyy</small>	Discharge Date <small>mm/dd/yyyy</small>
Hospital Record No.		Days Hospitalized	

Second Hospitalization

Name of hospital	Hospital address	Admission Date <small>mm/dd/yyyy</small>	Discharge Date <small>mm/dd/yyyy</small>
Hospital Record No.		Days Hospitalized	

Clinical Information

Did the patient have any of the following:

Fever >101 F (or >38.3 C) <i>Yes No Unknown</i>	If Yes, specify highest temperature:	Scale: <i>Fahrenheit Celsius</i>
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Thrombocytopenia (platelets less than or equal to 150,000 mm3) <i>Yes No Unknown</i>	Lowest platelet count	Elevated Hematocrit (Hct) <i>Yes No Unknown</i>	Highest Hct
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Elevated creatinine <i>Yes No Unknown</i>	Highest creatinine
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WBC	Total Neutrophils (%)	Banded Neutrophils (%)	Lymphocytes (%)
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CXR with unexplained bilateral interstitial infiltrates or suggestive of ARDS <i>Yes No Unknown</i>	If yes, date <small>mm/dd/yyyy</small>
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Respiratory compromise requiring supplemental oxygen? <i>Yes No Unknown</i>	Oxygen saturation <90% at any time? <i>Yes No Unknown</i>
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Was the patient intubated? <i>Yes No Unknown</i>	If yes, specify the date: <small>mm/dd/yyyy</small>	Has the patient received ribavirin? <i>Yes No Unknown</i>
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History of any relevant underlying medical conditions (i.e. COPD, malignancy, immunosuppression, diabetes)?	Other possible explanations for acute illness (i.e. sepsis, burns, trauma)?
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Outcome <i>Alive Dead Unknown</i>	If deceased, date of death: <small>mm/dd/yyyy</small>	Was an autopsy performed? <i>Yes No Unknown</i>
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If Yes, were results compatible with non-cardiogenic pulmonary edema? <i>Yes No Unknown</i>	Are tissue specimens (fresh-frozen or paraffin blocks) available for testing? <i>Yes No Unknown</i>
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Is serum/blood specimen available for testing for hantavirus infection? <i>Yes No Unknown</i>	Has a specimen been tested for hantavirus infection at another laboratory? <i>Yes No Unknown</i>
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If Yes, where?	Type of Specimen	Results (i.e. titer, OD)?
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History of any rodent exposure in 6 weeks prior to onset of illness? <i>Yes No Unknown</i>	If yes, date of contact: <small>mm/dd/yyyy</small>
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Type of rodent <small>(Check all that apply)</small> <i>Mouse Rat Other (specify) _____ Unknown</i>	Place of contact (town, county, state):
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Comments or Additional Information

Name of patient's physician:		
Last Name	First Name	Evening Phone <small>###-###-####</small>

Clinical Information cont.

Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-24, Atlanta, GA 30333; ATTN: PRA (0920-0009). Centers for Disease Control and Prevention Revised August 2002

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Comments or Additional Information

Comments or Additional Information

Remarks and/or Comments

Investigator's Name	Title	Phone number ###-###-####	Date of Investigation mm/dd/yyyy	Agency
Agency address				
City	State		Zip	