



**Severe Respiratory Illness (SRI)/Severe Acute Respiratory Syndrome (SARS)
Investigation Report Form, 2003-2004**

New Case **Case Update (only complete updated areas)** Provincial ID: _____

NOTE: If there is insufficient space on this form for information, or if you need room for multiple entries (e.g., more than one hospital, place of travel, hotel, flight, contact, etc.), please use the "Notes" section at the bottom to provide the additional information. If that is not enough room, please use an additional form(s), and indicate in the Notes section that it **accompanies** the initial case report form.

HEALTH AUTHORITY INFORMATION	
Date of report (dd/mm/yyyy): ___/___/_____	PHN/Person Reporting: _____
Health Unit Reporting: _____	Phone: _____
PATIENT INFORMATION	
Last name: _____	First name: _____
Occupation: <input type="checkbox"/> HCW <input type="checkbox"/> Other: _____	Date of Birth (dd/mm/yyyy): ___/___/_____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Ethnicity: <input type="checkbox"/> Caucasian <input type="checkbox"/> First Nations <input type="checkbox"/> Other _____
City of Primary Residence: _____	Postal Code: _____
CASE TYPE (refer to case definitions provided)	
<input type="checkbox"/> Confirmed SARS (clinical, radiographic, lab evidence of SARS; no alternate Dx) <input type="checkbox"/> Probable SARS (clinical, radiographic evidence of SARS; epidemiologic link to SARS; no alternate Dx) <input type="checkbox"/> SARS Symptomatic Contact (clinical symptoms of SARS; epidemiologic link to a person with SARS) <input type="checkbox"/> SARS Person Under Investigation (clinical symptoms of SARS; potential epidemiologic link to SARS) <input type="checkbox"/> Person hospitalized with SRI + epidemiologic link to SARS <input type="checkbox"/> Person in SRI cluster in Health Care Unit <input type="checkbox"/> Unknown	
If epi-linked to a person/place linked to SARS (confirmed or potential), please indicate link:	
<input type="checkbox"/> Returned from zone of re-emergence (ZRE) <input type="checkbox"/> Contact with traveler to ZRE <input type="checkbox"/> Lab worker handling live SARS Co-V <input type="checkbox"/> Link to nosocomial cluster	
CLINICAL INFORMATION	
Date symptom onset (dd/mm/yyyy)? ___/___/_____	Date fever onset (dd/mm/yyyy)? ___/___/_____
Fever >38° <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Headache <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Myalgia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Breathing Difficulty <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Rash <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other: _____
Chest X-Ray? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	CXR Date (dd/mm/yyyy): ___/___/_____
CXR Infiltrates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	CXR Summary: _____
Laboratory evidence of SARS Co-V? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Results Pending	
Patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Hospital Name: _____ City: _____	
Reason for hospitalization: <input type="checkbox"/> SARS <input type="checkbox"/> SRI/ARDS <input type="checkbox"/> Other: _____	
Admitted (dd/mm/yyyy): ___/___/_____ Discharged (dd/mm/yyyy): ___/___/_____ OR <input type="checkbox"/> Not discharged	
ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No Ventilated? <input type="checkbox"/> Yes <input type="checkbox"/> No Intubated? <input type="checkbox"/> Yes <input type="checkbox"/> No On O2? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Lowest O2 Sat: _____ Lowest platelet count: _____ WBC: _____ Diff: _____	
Current diagnosis: <input type="checkbox"/> ARDS <input type="checkbox"/> Atypical pneumonia <input type="checkbox"/> Other: _____	
Current disposition: <input type="checkbox"/> Recovered <input type="checkbox"/> Improving <input type="checkbox"/> Stable <input type="checkbox"/> Deteriorating <input type="checkbox"/> Deceased ___/___/_____	
If deceased, cause of death? _____ Autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If autopsied, findings consistent w/RDS pathology w/out identifiable cause? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Patient isolated? <input type="checkbox"/> Yes <input type="checkbox"/> No Isolated from (dd/mm/yyyy) ___/___/_____ to ___/___/_____	

SIGNIFICANT FACTORS		
Underlying medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If yes, <input type="checkbox"/> Heart <input type="checkbox"/> Lung <input type="checkbox"/> Immune System <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Other: _____		
Patient vaccinated for influenza in 2003/2004 season? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
EXPOSURE HISTORY		
Travel within 10 days of symptom onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, <input type="checkbox"/> Canada <input type="checkbox"/> International		
Country/city of travel: _____ Travel dates (dd/mm/yyyy): ___/___/___ to ___/___/___		
Hotel accommodation (name): _____ Dates (dd/mm/yyyy): ___/___/___ to ___/___/___		
During travel, contact with: <input type="checkbox"/> Hospital <input type="checkbox"/> Doctor's office <input type="checkbox"/> Person with ILI <input type="checkbox"/> SARS case <input type="checkbox"/> Unknown		
Flight within 10 days of symptom onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Flight: _____ Seat#: _____ City of origin: _____ Date (dd/mm/yyyy) ___/___/___		
Patient ill on flight? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Was patient on an organized tour? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Tour name: _____		
Patient ill on tour? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Tour dates (dd/mm/yyyy): ___/___/___ to ___/___/___		
Contact of previously identified case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Name of contact: _____		
Type of contact: <input type="checkbox"/> Household <input type="checkbox"/> Health Care Setting <input type="checkbox"/> Airline <input type="checkbox"/> Organized Tour <input type="checkbox"/> Other: _____		
First contact with case (dd/mm/yyyy): ___/___/___ Last contact with case (dd/mm/yyyy): ___/___/___		
In the 10 days prior to symptoms onset, did this person have direct contact with a:		
<input type="checkbox"/> person who works in a health care facility? <input type="checkbox"/> person who traveled to Asia? <input type="checkbox"/> area with SARS clusters?		
<input type="checkbox"/> person symptomatic w/febrile resp. illness? <input type="checkbox"/> Flight (if yes, flt#: _____) <input type="checkbox"/> None of the above <input type="checkbox"/> Unknown		
BLOOD PRODUCTS		
Did patient receive or donate blood in 10 days prior to symptom onset? <input type="checkbox"/> Received <input type="checkbox"/> Donated <input type="checkbox"/> Neither		
Did patient donate blood after symptoms onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
SPECIMENS COLLECTED		
Blood culture <input type="checkbox"/> Yes <input type="checkbox"/> No	Whole blood <input type="checkbox"/> Yes <input type="checkbox"/> No	Acute sera <input type="checkbox"/> Yes <input type="checkbox"/> No
Convalescent sera <input type="checkbox"/> Yes <input type="checkbox"/> No	Nasopharyngeal swab <input type="checkbox"/> Yes <input type="checkbox"/> No	Stool <input type="checkbox"/> Yes <input type="checkbox"/> No
Tracheal aspirate <input type="checkbox"/> Yes <input type="checkbox"/> No	Cerebral spinal fluid <input type="checkbox"/> Yes <input type="checkbox"/> No	BAL <input type="checkbox"/> Yes <input type="checkbox"/> No
Autopsy specimens <input type="checkbox"/> Yes <input type="checkbox"/> No	Other #1: _____	Other #2: _____
CASE CONTACTS		
List case contacts and type of contact (household, health care setting, airplane, school, work, etc.):		
Name: _____	Type of contact: _____	Contact date ___/___/___
Name: _____	Type of contact: _____	Contact date ___/___/___
Name: _____	Type of contact: _____	Contact date ___/___/___
Name: _____	Type of contact: _____	Contact date ___/___/___

Notes: _____
