

Middle East Respiratory Syndrome (MERS) Patient Under Investigation (PUI) Short Form

For Patients Under Investigation (PUIs), complete and send this form to eocreport@cdc.gov (subject line: MERS Patient Form) or fax to 770-488-7107. If you have questions, contact the CDC Emergency Operations Center (EOC) at 770-488-7100.

STATE ID:		Today's Date: MM/DD/YY		County:		City:		State:					
Interviewer's name:				Phone:		Email:							
Physician's name:				Phone/Pager:									
PUI Definition—Does the patient have:		(Please consult CDC website at http://www.cdc.gov/coronavirus/mers/case-def.html)											
1. Acute respiratory infection with fever ($\geq 38^{\circ}\text{C}$, 100.4°F) and cough? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown													
2. Clinical or radiographic evidence of pneumonia or acute respiratory distress syndrome (ARDS)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown													
3. Travel from the Arabian Peninsula or neighboring countries [†] 14 days before illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown													
If yes, which countries? _____					Date of travel to/from the Middle East: MM/DD/YY MM/DD/YY								
Patient Demographic Information													
1. Sex: <input type="checkbox"/> M <input type="checkbox"/> F 2. Age: _____ <input type="checkbox"/> yr <input type="checkbox"/> mo 3. Residency: <input type="checkbox"/> US resident <input type="checkbox"/> non US resident, country: _____													
Clinical Presentation, History and Risk Factors													
4. Date of symptom onset: MM/DD/YY													
5. Symptoms (Check all that apply): <input type="checkbox"/> Fever <input type="checkbox"/> Dry cough <input type="checkbox"/> Productive cough <input type="checkbox"/> Chills <input type="checkbox"/> Sore throat <input type="checkbox"/> Headache <input type="checkbox"/> Muscle aches <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other _____													
6. In the 14 days before symptom onset did the patient have close contact with a recent ill traveler from the Arabian Peninsula or neighboring countries [†] ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, which countries? _____													
7. Is the patient (Check all that apply): <input type="checkbox"/> Health care worker (HCW) <input type="checkbox"/> US military <input type="checkbox"/> Flight crew <input type="checkbox"/> Other _____													
8. Concurrent risk factors (Check all that apply): <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Pregnant <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____													
Clinical Outcomes													
9. Is/Was the patient:					10. Is/Has patient receiving/received a diagnosis of:								
a. Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date: MM/YY/DD					Pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown								
b. Admitted to ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					ARDS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown								
c. Intubated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					Renal failure? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown								
11. Does the patient have a non-MERS etiology for their respiratory illness but has not responded to appropriate therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					12. Has the patient died? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown								
Infection Control													
13. When hospitalized, is/was the patient in a:					14. Are/Were surgical masks being used by the patient during transport?								
a. Negative pressure room? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown								
b. Private room? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown													
15. What personal protective equipment are/were being used by HCW when entering the patient's room (Check all that apply): <input type="checkbox"/> Gloves <input type="checkbox"/> Gowns <input type="checkbox"/> Eye protection (goggles or face shield) <input type="checkbox"/> N95/other form of respiratory protection (e.g., PAPR) <input type="checkbox"/> Facemask <input type="checkbox"/> Unknown													
Laboratory Testing													
Tests Performed		Results				Tests Performed		Results					
		+	-	Pending (Pe)	Not done			+	-	Pending (Pe)	Not done		
Influenza <input type="checkbox"/> A <input type="checkbox"/> B				<input type="checkbox"/>	<input type="checkbox"/>	Streptococcus pneumoniae				<input type="checkbox"/>	<input type="checkbox"/>		
RSV				<input type="checkbox"/>	<input type="checkbox"/>	Legionella pneumophila				<input type="checkbox"/>	<input type="checkbox"/>		
Human metapneumovirus				<input type="checkbox"/>	<input type="checkbox"/>	Blood culture				<input type="checkbox"/>	<input type="checkbox"/>		
Parainfluenza 1-4				<input type="checkbox"/>	<input type="checkbox"/>	If positive _____				<input type="checkbox"/>	<input type="checkbox"/>		
Adenovirus				<input type="checkbox"/>	<input type="checkbox"/>	Other: _____				<input type="checkbox"/>	<input type="checkbox"/>		
MERS Testing													
Specimen [‡]	ID #	Date collected	State			Sent to CDC?	Specimen [‡]	ID #	Date collected	State			Sent to CDC?
			+	-	Pe					+	-	Pe	
NP/OP		MM/DD/YY			<input type="checkbox"/>	PF		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>	
Sputum		MM/DD/YY			<input type="checkbox"/>	Stool		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>	
BAL		MM/DD/YY			<input type="checkbox"/>	Serum		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>	
TA		MM/DD/YY			<input type="checkbox"/>			MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>	

[†]Countries considered in the Arabian Peninsula and neighboring include: Bahrain, Iraq, Iran, Israel, Jordan, Kuwait, Lebanon, Oman, Palestinian territories, Qatar, Saudi Arabia, Syria, the United Arab Emirates (UAE), and Yemen.

[‡]NP/OP, Nasopharyngeal/Oropharyngeal swab; BAL, Bronchoalveolar lavage; TA, Tracheal aspirate; PF, Pleural fluid