



# Connecticut Department of Public Health

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

As soon as possible, notify the State of Connecticut Department of Public Health (DPH) at 860-509-7994 (weekdays) or at 860-509-8000 (evenings/weekends/holidays). Please fax the completed form to the DPH Epidemiology & Emerging Infections Program at: 860-509-7910

Physician name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Patient name: \_\_\_\_\_ Sex: M F DOB: \_\_\_\_\_ MR# \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Race/ethnicity \_\_\_\_\_ Residency: US resident non-US resident, country: \_\_\_\_\_

Date of symptom onset: \_\_\_\_\_ Symptoms (mark all that apply): Fever Chills Cough Sore throat  
Shortness of breath Muscle aches Vomiting Diarrhea Other: \_\_\_\_\_

**In the 14 days before symptom onset did the patient (mark all that apply):**

Have close contact<sup>1</sup> with a known MERS case while the case was ill?

Have close contact<sup>1</sup> with an ill traveler from the Arabian Peninsula/neighbor country<sup>2</sup>? If Yes, countries: \_\_\_\_\_

Was a patient, visited or worked in a health care facility in the Arabian Peninsula/neighbor country<sup>2</sup>? If Yes, countries: \_\_\_\_\_

Travel to/from the Arabian Peninsula or a neighbor country<sup>2</sup>? If Yes, countries: \_\_\_\_\_

Date of travel **TO** this area: \_\_\_\_\_ Date of travel **FROM** this area: \_\_\_\_\_

Is the patient a member of a severe respiratory illness cluster of unknown etiology? Yes No Unknown

Is the patient a health care worker (HCW)? Yes No Unknown If Yes, did the patient work as a HCW in/near a country in the Arabian Peninsula<sup>2</sup> in the 14 days before symptom onset? Yes No Unknown If Yes, countries: \_\_\_\_\_

Did the patient or a household member have any exposure to camels? Yes, describe \_\_\_\_\_ No Unknown

Does the patient have any comorbid conditions? (mark all that apply): None Unknown Diabetes Cardiac disease Hypertension  
Asthma Chronic pulmonary disease Immunocompromised Other: \_\_\_\_\_

|                                                                                                     | Yes | No | Unknown |
|-----------------------------------------------------------------------------------------------------|-----|----|---------|
| Was the patient: Hospitalized? If Yes, hospital: _____ Admission date: _____                        |     |    |         |
| Admitted to the Intensive Care Unit (ICU)?                                                          |     |    |         |
| Intubated?                                                                                          |     |    |         |
| Did the patient die? If Yes, date of death: _____                                                   |     |    |         |
| Did the patient have clinical or radiologic evidence of pneumonia?                                  |     |    |         |
| Did the patient have clinical or radiologic evidence of acute respiratory distress syndrome (ARDS)? |     |    |         |

| General non-MERS-CoV Pathogen Laboratory Testing (mark all that apply) |     |     |         |          |                                    |     |     |         |          |
|------------------------------------------------------------------------|-----|-----|---------|----------|------------------------------------|-----|-----|---------|----------|
| Pathogen                                                               | Pos | Neg | Pending | Not Done | Pathogen                           | Pos | Neg | Pending | Not Done |
| Influenza A PCR                                                        |     |     |         |          | Rhinovirus and/or Enterovirus      |     |     |         |          |
| Influenza B PCR                                                        |     |     |         |          | Coronavirus ( <u>not</u> MERS-CoV) |     |     |         |          |
| Influenza Rapid Test                                                   |     |     |         |          | Chlamydia pneumoniae               |     |     |         |          |
| RSV                                                                    |     |     |         |          | Mycoplasma pneumoniae              |     |     |         |          |
| Human metapneumovirus                                                  |     |     |         |          | Legionella pneumophila             |     |     |         |          |
| Parainfluenzavirus                                                     |     |     |         |          | Streptococcus pneumoniae           |     |     |         |          |
| Adenovirus                                                             |     |     |         |          | Other: _____                       |     |     |         |          |

| MERS-CoV rRT-PCR Testing (mark all that apply)                 |                |          |          |           |         |          |  |
|----------------------------------------------------------------|----------------|----------|----------|-----------|---------|----------|--|
| Specimen Type                                                  | Date Collected | Positive | Negative | Equivocal | Pending | Not Done |  |
| Sputum                                                         |                |          |          |           |         |          |  |
| Bronchoalveolar lavage (BAL)                                   |                |          |          |           |         |          |  |
| Tracheal Aspirate                                              |                |          |          |           |         |          |  |
| NP <sup>3</sup> OP <sup>3</sup> NP/OP <sup>3</sup> (check one) |                |          |          |           |         |          |  |
| Serum                                                          |                |          |          |           |         |          |  |
| Other: _____                                                   |                |          |          |           |         |          |  |

<sup>1</sup> Close contact is defined as: a) being within approximately 6 feet (2 meters) or within the room or care area for a prolonged period of time (e.g., healthcare personnel, household members) while not wearing recommended personal protective equipment (i.e., gowns, gloves, respirator, eye protection); or b) having direct contact with infectious secretions (e.g., being coughed on) while not wearing recommended personal protective equipment. Data to inform the definition of close contact are limited. At this time, brief interactions, such as walking by a person, are considered low risk and do not constitute close contact.

<sup>2</sup> Countries considered in and near the Arabian Peninsula include: Bahrain; Iraq; Iran; Israel, the West Bank and Gaza; Jordan; Kuwait; Lebanon; Oman; Qatar; Saudi Arabia; Syria; the United Arab Emirates (UAE); and Yemen.

<sup>3</sup> NP = nasopharyngeal, OP = oropharyngeal (throat swab)