

Middle East Respiratory Syndrome (MERS) Patient Under Investigation (PUI)¹ Short Form

*Local health departments should submit this report to the regional health department.
Regional health departments should fax this report to 512-776-7616.*

Patient's Name:	Address:	City:	County:	State:
Date of Birth:	Home Phone:	Cell Phone:	Email:	

STATE ID:	Date of Report:	City:	County:	State:
Investigator's name:	Phone:	Email:	Investigation Start Date:	
Physician's name:	Phone/Pager:			
Reporter's Name:	Phone:	Email:		

PATIENT DEMOGRAPHIC INFORMATION

Sex: M F Age: _____ yr mo Residency: US resident Non-US resident, country: _____

Race: White Black Asian Pacific Islander Native American/Alaskan Unknown Other: _____

Hispanic: Yes No Unknown

CLINICAL PRESENTATION, HISTORY, AND RISK FACTORS

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 contact² with a known MERS case?
 If Yes, date(s) of contact with known MERS case: _____ Name/ID of known MERS case: _____
- Have close contact² with an ill traveler from the Arabian Peninsula/neighboring country³?
 If Yes, collect the following information for the ill person who traveled to the Arabian Peninsula/neighboring country:
 Illness onset date: _____ Symptoms: Fever Acute respiratory illness Pneumonia Other illness: _____
 Countries visited: _____ Dates of travel: _____
- If Yes, collect the following information for the patient currently under evaluation who had close contact with the ill traveler:
 Date(s) of close contact with ill traveler: _____
- Visit or work in a health care facility in the Arabian Peninsula/neighboring country³?
 If Yes, countries: _____
- Travel to/from the Arabian Peninsula/neighboring country³?
 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 Peninsula³ in the 14 days before symptom onset?

Yes No Unknown If Yes, countries: _____

¹ PUI definition – please consult CDC website at <http://www.cdc.gov/coronavirus/mers/case-def.html>.

² 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. Infection control guidance: <http://www.cdc.gov/coronavirus/mers/infection-prevention-control.html>

³ Countries considered in the Arabian Peninsula and neighboring 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.

⁴ NP = nasopharyngeal, OP = oropharyngeal (throat swab)

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

CLINICAL OUTCOMES

Is/Was the patient:

Hospitalized? Yes No Unknown

If Yes, Hospital: _____ Admission date: _____ Discharge date: _____

Admitted to ICU? Yes No Unknown

Intubated? Yes No Unknown

Did the patient die? Yes No Unknown

If Yes, Date of death: _____

Did the patient have clinical or radiologic evidence of pneumonia? Yes No Unknown

Did the patient have clinical or radiologic evidence of acute respiratory distress syndrome (ARDS)? Yes No Unknown

INFECTION CONTROL

When hospitalized, is/was the patient in a:

Negative pressure room? Yes No Unknown

Private room? Yes No Unknown

Are/Were surgical masks being used by the patient during transport? Yes No Unknown

What personal protective equipment are/were being used by HCWs when entering the patient's room? (mark all that apply)

Gloves Gowns Eye protection (goggles/face shield) N95 or other similar or higher form of respiratory protection (e.g., PAPR)

Facemask Unknown Other: _____

LABORATORY TESTING

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 (not MERS-CoV)				
Influenza Rapid Test					<i>Chlamydophila pneumoniae</i>				
RSV					<i>Mycoplasma pneumoniae</i>				
Human metapneumovirus					<i>Legionella pneumophila</i>				
Parainfluenza virus					<i>Streptococcus pneumoniae</i>				
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 ⁴ OP ⁴ NP/OP ⁴ (circle one)						
Serum						
Other: _____						

For CDC ONLY:	Date Collected	Positive	Negative	Pending	Not Done
MERS-CoV Serology Testing					

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