

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

For PUI, complete and send this form to [eocevent90@cdc.gov](mailto:eocevent90@cdc.gov) (subject line: MERS Form) or fax to 770-488-7107.  
If you have questions contact the CDC Emergency Operations Center (EOC) at 770-488-7100.

<b>STATE ID:</b>	<b>Today's Date:</b> MM/DD/YY	<b>County:</b>	<b>City:</b>	<b>State:</b>
<b>Interviewer's name:</b>	<b>Phone:</b>	<b>Email:</b>		
<b>Physician's name:</b>		<b>Phone/Pager:</b>		

**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 ( $\geq 38^{\circ}\text{C}$ ,  $100.4^{\circ}\text{F}$ ) and cough?**  Yes  No  Unknown  
 2. **Clinical or radiographic evidence of pneumonia or acute respiratory distress syndrome (ARDS)?**  Yes  No  Unknown  
 3. **Travel from the Arabian Peninsula or neighboring countries<sup>†</sup> 14 days before illness onset?**  Yes  No  Unknown  
 If yes, which countries? \_\_\_\_\_ Date of travel to/from the Middle East: MM/DD/YY | MM/DD/YY

**Patient Demographic Information**

1. **Sex:**  M  F    2. **Age:** \_\_\_\_\_  yr  mo    3. **Residency:**  US resident  non US resident, country: \_\_\_\_\_

**Clinical Presentation, History and Risk Factors**

4. **Date of symptom onset:** MM/DD/YY

5. **Symptoms** (Check all that apply):  Fever  Dry cough  Productive cough  Chills  Sore throat  Headache  
 Muscle aches  Shortness of breath  Vomiting  Abdominal pain  Diarrhea  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<sup>†</sup>?**  Yes  No  Unknown If yes, which countries? \_\_\_\_\_

7. **Is the patient** (Check all that apply):  Health care worker (HCW)  US military  Flight crew  Other \_\_\_\_\_

8. **Concurrent risk factors** (Check all that apply):  Immunocompromised  Pregnant  Unknown  
 Other \_\_\_\_\_

**Clinical Outcomes**

<p>9. <b>Is/Was the patient:</b></p> <p>a. Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date: MM/YY/DD</p> <p>b. Admitted to ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>c. Intubated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>10. <b>Is/Has patient receiving/received a diagnosis of:</b></p> <p>Pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>ARDS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Renal failure? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
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11. **Does the patient have a non-MERS etiology for their respiratory illness but has not responded to appropriate therapy?**  Yes  No  Unknown

12. **Has the patient died?**  Yes  No  Unknown

**Infection Control**

13. **When hospitalized, is/was the patient in a:**

a. Negative pressure room?  Yes  No  Unknown

b. Private room?  Yes  No  Unknown

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

15. **What personal protective equipment are/were being used by HCW when entering the patient's room** (Check all that apply):

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

Facemask  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 <sup>‡</sup>	ID #	Date collected	State			Sent to CDC?	Specimen <sup>‡</sup>	ID #	Date collected	State			Sent to CDC?
			+	-	Pe					+	-	Pe	
NP/OP		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>	PF		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>
Sputum		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>	Stool		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>
BAL		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>	Serum		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>
TA		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>			MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>

<sup>†</sup>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.

<sup>‡</sup>NP/OP, Nasopharyngeal/Oropharyngeal swab; BAL, Bronchoalveolar lavage; TA, Tracheal aspirate; PF, Pleural fluid