National Centre for Disease Control, Delhi-54
Investigation Form MERS Coronavirus (MERS-CoV)

State:	**Reporting District:**
Patient's name:	**Father's name:**
Patient's address of residence & contact details including phone:	
Interviewer's name: **Phone:** **Email:**	
Date of report:	☐ **New report** ☐**Update to previous report**

1. Age (years): **Age in months If aged less than 1 year:**
2. Sex: **3. Occupation:** _____ **4. Date of illness onset:**

5. Describe Symptoms: ☐ Fever ☐ Runny Nose ☐ Sneezing ☐ Cough ☐ Sore Throat ☐ Shortness of Breath
Other symptoms: _____

6. Did patient travel to Middle East or any other affected country in the 14 days prior to illness onset? ☐ Yes ☐ No ☐ Unknown

If yes, which countries?
Depart Date Return Date Location
1)
2)

7. Did patient have contact with someone else who traveled to the Middle East or any other affected country in the 14 days prior to illness onset?
☐ Yes ☐ No ☐Unknown
If yes, what is relation?
Which countries?
Depart Date Return Date Location
1)
2)

8. In the 14 days before onset did the patient have close contact with any of the following: ☐ Cows ☐ Bats ☐ Goats ☐ Camels ☐ Sheep ☐ Poultry bird ☐ Duck ☐ Live Animal Market ☐ Other animals, If other, what animals? _____

9. Does patient work as a health care worker?
☐ Yes ☐ No ☐ Unknown
If Yes, name and city of facility: _____

10. Did patient have contact with a person with ARI/Pneumonia in the 14 days prior to illness onset?
☐ Yes ☐ No ☐ Unknown **If yes, describe** *(e.g., Case is sibling of a confirmed case)*_____

11. Diagnosis of pneumonia?
☐ Yes ☐ No ☐ Unknown
If Yes: ☐ Clinical ☐ Radiographic ☐ Other
If other:

12. Was the patient hospitalized for this illness?
☐ Yes ☐ No ☐ Unknown
Hospitalization Date: Discharge Date:
If Yes, hospital name & city:

13. Admitted to ICU
☐ Yes ☐ No ☐ Unknown
ICU Start Date:
ICU Discharge Date:

14. Mechanical Ventilation
☐ Yes ☐ No ☐ Unknown
If known, Start Date:
Duration (days):

15. Acute Respiratory Distress Syndrome
☐ Yes ☐ No ☐ Unknown **Date:**

16. Renal failure
☐ Yes ☐ No ☐ Unknown

17. Fatality
☐ Yes ☐ No ☐ Unknown
If Yes, Date: _____ **Cause of death:**_____ _____

18. Medical History (Please tick all that apply): Cortisone therapy/ Immunosuppressive therapy/ HIV-AIDS/ Diabetes Mellitus/ Chronic Lung Disease/ Chronic Heart Disease/ Chronic Kidney Disease/ Chronic Liver Disease/ Cancer/ Blood Disorders/Neurological Disorders/ Any other _____

19. Type of Respiratory sample collected
Respiratory Sample Collected MERS CoV
☐ **Tracheal Aspirate**
☐ **Bronchoalveolar lavage**
☐ **Any other**

20. Results of any tests performed for respiratory viruses/bacteria? ☐ Yes ☐ No ☐ Unknown

Specimen Type:	**Type of test:**	**Date of test:**	**Result of test:**
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21. Is a specimen being sent to NCDC for testing? ☐ Yes ☐ No ☐ Unknown If Yes, ID#, Name & Age:

22. Treatment given in the hospital (brief):

Fill out the form above and send to idsp-npo@nic.in. Call at Tel: 011- 23981607 for further assistance. If information is incomplete, please send any information you have as soon as possible then send an updated form when you obtain more information.