MINISTRY OF HEALTH & WELLNESS

National Surveillance Unit, National Epidemiology Branch,
Ministry of Health and Wellness,
15 Knutsford Boulevard, Kingston 5, Telephone 876-633-7937

SARI CASE INVESTIGATION FORM

INITIAL DIAGNOSIS

Severe Acute Respiratory Illness

Date of Notification: DD/MM/YYYY	Date Investigation Started: DD/MM/YYYY

PATIENT'S DEMOGRAPHICS

Patient's ID Type: ◯ Driver's License ◯ TRN ◯ Passport ◯ NIN	Patient's ID Number:
First Name:	Middle Name(s):
Last Name:	Pet Name(s):
Sex Assigned at Birth: ◯ Male ◯ Female	Medical Record Number:
Date of Birth: DD/MM/YYYY	Age:
Country of Residence:	Parish (Jamaica):
House Number, Street Name:	
Landmark or directions to address:	Community:
Phone Number:	Email Address:
Occupation:	
Name of Workplace/School:	
Address of School/Workplace:	
Phone Number:	Email Address:

CLINICAL PROFILE

◯ History of Fever ◯ Recorded Fever

Recorded temperature:	Duration (days):	Date of Onset: DD/MM/YYYY

Sign or Symptom	Presence	Date of Onset
Cough	◯Yes ◯No ◯Unknown	DD/MM/YYYY
Rhinorrhoea	◯Yes ◯No ◯Unknown	DD/MM/YYYY
Sore throat	◯Yes ◯No ◯Unknown	DD/MM/YYYY
Shortness of breath	◯Yes ◯No ◯Unknown	DD/MM/YYYY
Difficulty breathing	◯Yes ◯No ◯Unknown	DD/MM/YYYY
Wheezing	◯Yes ◯No ◯Unknown	DD/MM/YYYY
Otitis	◯Yes ◯No ◯Unknown	DD/MM/YYYY
Conjunctivitis	◯Yes ◯No ◯Unknown	DD/MM/YYYY
Headache	◯Yes ◯No ◯Unknown	DD/MM/YYYY
Myalgia	◯Yes ◯No ◯Unknown	DD/MM/YYYY
Lymphadenopathy	◯Yes ◯No ◯Unknown	DD/MM/YYYY
Vomiting	◯Yes ◯No ◯Unknown	DD/MM/YYYY
Diarrhoea	◯Yes ◯No ◯Unknown	DD/MM/YYYY
Rash	◯Yes ◯No ◯Unknown	DD/MM/YYYY
Other: ____________________________	◯Yes ◯No ◯Unknown	DD/MM/YYYY

Medical History

Pre-existing Conditions

◯ Asthma	◯ Diabetes mellitus	◯ HIV/AIDS	◯ Malignancy
◯ Autoimmune	◯ Heart disease	◯ Hypertension	◯ Sickle cell disease
◯ Chronic obstructive pulmonary disease (COPD)	◯ Kidney disease	◯ Liver dysfunction	◯ Other Specify Other:

Obesity: ◯Yes ◯No ◯Unknown

BMI Category: ◯ <18.5 ◯ 18.5 -24.9 ◯25-29.9 ◯ 30-34.9 ◯≥35 ◯Unknown

Additional risk factors in children under 2 years only

◯ Prematurity	◯ Malnutrition
◯ Low birth weight	◯ Not exclusively breastfed (up to 6 months)

Pregnancy

Is patient pregnant: ◯ Yes ◯ No ◯ Unsure ◯ Not Applicable

Gestational Age: ________________weeks

Trimester: ◯ First ◯ Second ◯ Third

VACCINATION HISTORY

Influenza vaccine administered in the previous 12 months? ◯Yes ◯No ◯Unknown

Date of last dose: *DD/MM/YYYY*

Source of vaccination Information: ◯Verbal/Self ◯ Medical Record ◯Vaccination Card

CASE MANAGEMENT AND INVESTIGATION

Exposure Profile

Did the patient have contact with animals ◯ Yes ◯ No ◯ Unknown

Select all that apply If there was animal contact: ◯ Avian/Poultry ◯ Swine ◯ Equine ◯ Bovine ◯ Other ___________________

Are there other cases present in the community of residence? ◯ Yes ◯ No

Are there other cases present in the workplace/school? ◯ Yes ◯ No

Travelled in the last 6 weeks: ◯ Yes ◯ No ◯ Unknown

If travelled: ◯ Domestic Travel ◯ International Travel ◯ Domestic and International Travel

If travelled, fill out the table below:

Country Visited	City Visited	Date Arrived in Country	Date Departed Country
		DD/MM/YYYY	*DD/MM/YYYY*
		DD/MM/YYYY	*DD/MM/YYYY*
		DD/MM/YYYY	*DD/MM/YYYY*

Date returned to Jamaica: *DD/MM/YYYY*

If Local Travel, fill out the table below:

Address	Parish	Date Arrived	Date Departed
		DD/MM/YYYY	*DD/MM/YYYY*
		DD/MM/YYYY	*DD/MM/YYYY*
		DD/MM/YYYY	*DD/MM/YYYY*
		DD/MM/YYYY	*DD/MM/YYYY*

HOSPITAL SUMMARY

Admitted to Hospital? ◯ Yes ◯ No | Date of Admission: DD/MM/YYYY | Date of Discharge: DD/MM/YYYY

Hospital: | Medical Record Number:

Vital Status (Outcome): ◯ Alive ◯ Dead | Date of Death: DD/MM/YYYY | Time of Death: __:__ AM/PM

Admitted to ICU: ◯ Yes ◯ No | Date of Admission: DD/MM/YYYY | Date of Discharge: DD/MM/YYYY

Place of Death: ◯ Home ◯ DOA ◯ Ward ◯ ICU ◯ Other

Summary of Clinical Management:

SAMPLE AND LAB INFORMATION

Specimen Number	Specimen Type	Date Specimen Collected	Date Specimen Sent to Lab	Date/time received by laboratory	Adequacy for testing	Quantitative Test result	Test result (Virus Isolation
	Nasopharyngeal Swab	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	◯ Satisfactory - analysed ◯ Unsatisfactory- analysed ◯ Unsatisfactory – not analysed		
	Sputum Sample	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	◯ Satisfactory - analysed ◯ Unsatisfactory- analysed ◯ Unsatisfactory – not analysed		
		DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	◯ Satisfactory - analysed ◯ Unsatisfactory- analysed ◯ Unsatisfactory – not analysed		

Which lab is the sample being sent to?
◯ National Public Health Laboratory ◯ University of the West Indies (NIC) ◯ Other

Specify Other Laboratory:

Classification

Index Diagnosis: SARI | **Final Diagnosis:**

If SARI:

◯ Influenza	◯ Pneumococcal pneumonia	◯ Parainfluenza	◯ Chlamydia pneumonia
◯ COVID- 19	◯ Diphtheria	◯ Group A Streptococcal pneumonia	

Influenza Subtype (If applicable):

Final classification:

◯ Laboratory Confirmed	◯ Probable	◯ Suspected
◯ Pending	◯ Inconclusive	◯ Discarded

Reason for classification:

Epidemiological Link:

◯ Human to human transmission	◯ Animal to human transmission	◯ Environmental exposure

Aetiology Category: ◯ Imported case ◯ Import-related cases ◯ Endemic ◯ Unknown

Source country (If Imported or Import-Related:

DEATH CLASSIFICATION

Contribution to patient death: ◯ Yes ◯ No ◯ Unknown

Immediate Cause:

Intermediate Cause:

Underlying Cause:

Investigator's Comments:

Investigator's Details

Date Investigation Completed: *DD/MM/YYYY*

First Name:

Last Name

Professional Group:

Phone number:

Email Address:

Name of Institution:

Community:

Parish:

Investigator's Office Number/Street Name:

Investigator's Health Region:

Name of Parish MO(H):	Signature of MO(H):	Date signed by MO(H): *DD/MM/YYYY*