Middle East Respiratory Syndrome Coronavirus (MERS-CoV)

**Initial Interview Questionnaire of Cases v2**

**Guide for the interviewer**

**v2 Updated May 2017**

*Reason for update: v2 has been updated taking into consideration knowledge of potential and suspected risk factors for infection and severe disease*

This form is designed to gather initial information about the potential exposures of a suspected or confirmed case of MERS- CoV infection in the 14 days before symptom onset. The interview should be conducted as soon as possible once the patient is suspected of having MERS-CoV infection. If the patient is unable to personally answer questions because of death or severity of illness, a close relative or friend can answer the questions for him or her. This form should be modified according to local needs and experience.

**This form is not intended as a formal study instrument but rather questions that will allow investigators better understand potential exposures that may have led to infection and to develop hypotheses to test during subsequent formal studies.**

Purpose of form: This interview form is developed as a supplemental tool to accompany the WHO guidelines for investigation of cases of human infection with MERS-CoV, which can be found on the WHO website. **This is not an investigation form.**

 1. Patient Information

* 1. Patient Name (Family Name/First Name)
	2. Case identification number/Identification number
	3. Residence (country, city, province)

OR GPS coordinates Lat Long

* 1. Residence type:

1.5 Subject is:

Single family home Dormitory

Person under investigation

(including contact)

Apartment

Other, please specify Probable Case Confirmed Case

* 1. Person answering questions is:

Subject/Patient

Relative (specify relationship)

Acquaintance/co-worker (specify relationship):

* 1. Sex Male Female
	2. Age (in years if over 1 year old, in months if <1 year old) years months (if under 1)
	3. Date of interview (dd/mm/yyyy) / /

|  |  |  |
| --- | --- | --- |
| 1.10. Date of symptom onset (dd/mm/yyyy) / /  |  | Tick box for no symptoms at time of interview |
| 2. Contact with confirmed MERS patient |
| 2.1. Have you had contact with known confirmed case? |  | Yes |  | No |  | Unknown |

* + 1. If yes, provide details of confirmed case (name, ID number)
		2. What is your relationship with confirmed case? Relative Co-worker

other (please specify)

* + 1. What are the dates of your first and last contact with the confirmed case (dd/mm/yyyy)?
			1. First contact / /
			2. Last contact / /
		2. What is the nature of contact with the confirmed case (check all that apply)?

Direct contact Indirect contact (shared room with patient)

Provided patient care Indirect contact (spoke with patient)

Other, please specify Unknown

|  |
| --- |
| 3. Health Care Visits |
| 3.1. Have you visited a health care facility in the 14 days prior to symptom onset? |  | Yes |  | No |  | Unknown |

3.1.1. If yes, where and when were the health care visit(s)?

Health Care Facility Name Inpatient or Outpatient Date admitted Date released

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1  |  | In |  | Out |  / /  |  / /  |
| 2  |  | In |  | Out |  / /  |  / /  |
| 3  |  | In |  | Out |  / /  |  / /  |
| 4  |  | In |  | Out |  / /  |  / /  |

|  |
| --- |
| 4. Recent travel |
| 4.1. Have you travelled in the 14 days prior to symptom onset? |  | Yes |  | No |  | Unknown |

* + 1. If yes, where and when was the travel? Location 1 Location 2 Location 3

Dates (from when to when): Dates (from when to when): Dates (from when to when):

* + 1. If yes, did you visit any health care facilities while traveling?

*If yes, please list in 3.1.1*

* + 1. If yes, did you have contact with dromedary camels while traveling?
		2. If yes, ware you symptomatic during travel?

Yes No

Yes No

Yes No

Unknown

Unknown Unknown

* + - 1. Indicate the mode of travel and any travel related information (e.g., date, mode of travel, from-to, flight/train/bus number or timing of dep/arr)
		1. If yes, did you attend any mass gatherings while traveling?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 5.1.1. Was the contact direct (i.e., touched the camel)? |  | Yes |  | No |  | Unknown |
| Cared for camel |  | Yes |  | No |  | Unknown |
| Slaughtered a camel |  | Yes |  | No |  | Unknown |
| Milked a camel |  | Yes |  | No |  | Unknown |
| Other, please specify  |  | Yes |  | No |  | Unknown |
| 5.1.2. Was the contact indirect? |  |  |  |  |  |  |
| Visited a camel market |  | Yes |  | No |  | Unknown |
| Visited a camel farm |  | Yes |  | No |  | Unknown |
| Visited a camel race track |  | Yes |  | No |  | Unknown |
| Other  |  | Yes |  | No |  | Unknown |

* 1. Have any of your family members had direct contact with dromedaries in the 14 days prior to your symptom onset?

Mass sporting event

Hajj

Umrah

Family celebration

Other

1. Dromedary camel contact
	1. Have you had contact with dromedary camels in the 14 days prior to symptom onset? Yes No Unknown

Yes No Unknown

* + 1. If yes, who had contact with the camel and where was the contact?
	1. Have any of your family members visited a camel farm/camel race track or camel

market in the 14 days prior to symptom onset? Yes No Unknown

* + 1. If yes, when and where? / / Location:
	1. Has you had any contact with raw camel materials?
		1. If yes, which materials (check all that apply):

Yes No

Unknown

handled/consumed unpasteurized camel milk handled/consumed camel blood

handled/consumed camel urine

handled/consumed uncooked camel meat or organs

Other, please specify

6. Other animal contact

5.1. Have you had direct contact with animals other than dromedary camels in the 14 days prior to symptom onset?

Yes No Unknown

If yes, list the animals species here:

|  |
| --- |
| 7. Underlying medical conditions |
| 7.1. Do you have any underlying medical conditions? |  | Yes |  | No |  | Unknown |

* + 1. If yes, which conditions?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Diabetes |  | Yes |  | No |  | Unknown |
| Heart Disease, including hypertension |  | Yes |  | No |  | Unknown |
| Renal Disease |  | Yes |  | No |  | Unknown |
| Weakened immune system (from cancer, chemotherapy, radiation therapy, immunosuppressive medications, |
| HIV, organ transplant, or inherited immunodeficiency) |  | Yes |  | No |  | Unknown |
| Obesity |  | Yes |  | No |  | Unknown |
| Asthma |  | Yes |  | No |  | Unknown |
| Chronic lung disease, including COPD |  | Yes |  | No |  | Unknown |
| Liver disease |  | Yes |  | No |  | Unknown |

Other, please specify

* + 1. If female, are you pregnant? Yes No Unknown

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 7.2. Are you currently a smoker? |  | Yes |  | No |
| 7.2.1. If no, are you formerly a smoker? |  | Yes |  | No |
| 8. Patient occupation |

8.1. What is your occupation?

9. Identification of interviewer and interviewee

Student, name school/university

Employed, health care worker\*, specify job:

Unemployed Retired

Other, please specify

Employed, non HCW, specify occupation Camel worker

*\*if Health Care worker, fill in health care worker form*

* 1. Form completed by (name)
	2. Contact information of interviewer (mobile number)
	3. Date of interview (dd/mm/yyyy) / /