



**EXPOSURE HISTORY**

**Contact of a previously identified SRI/SARS case?**  Yes  No  Don't Know  
**If yes**, contact case status –  Confirmed  Probable  Don't Know → SRI/SARS Case ID (specify): \_\_\_\_\_  
**If yes**, type of contact:  Household  Health care setting  Airline  Other (specify): \_\_\_\_\_  
**If yes**, date of: First contact with case: \_\_\_\_/\_\_\_\_/\_\_\_\_ (dd/mm/yyyy) Last contact: \_\_\_\_/\_\_\_\_/\_\_\_\_ (dd/mm/yyyy)

**In the 10 days prior to symptoms onset, was the patient in close contact with anyone who:**  
 Works in a health care facility?  Yes  No  Don't Know  
 Travelled to a zone of emergence/re-emergence (China/Taiwan/Hong Kong)  Yes  No  Don't Know  
 or to a currently affected area\* in Canada? (\*refer to SRI Enhanced Surveillance Definition at <http://www.sars.gc.ca>)  
 Works in a laboratory handling / storing SARS CoV?  Yes  No  Don't Know

**Did the patient travel by airplane in the 10 days prior to onset of symptoms?**  Yes  No  Don't Know  
**If yes**, specify flight number(s), carrier(s), seat number(s), city(s) of origin and date(s) of flight(s):

Flight #	Carrier	Seat #	City of Origin	Date of flight (dd/mm/yyyy)

**TRAVEL RELATED**

**Recent travel to a zone of emergence/re-emergence (ZRE) of SARS (i.e. China, including mainland China, Taiwan and Hong Kong SAR) or to a currently affected area\* in Canada?** (\*refer to SRI Enhanced Surveillance Definition at <http://www.sars.gc.ca>)  
 Yes  No  Don't Know

**If Yes**, specify country(s)/area(s), hotel(s)/residence(s) stayed in and dates of arrival and departure:

Country / Area	Province / City	Hotel / Residence	Date of Arrival	Date of Departure

**If travelled to a zone of emergence/re-emergence (China/Taiwan/Hong Kong) or to a currently affected area\* in Canada, indicate possible exposure(s):** (\*refer to SRI Enhanced Surveillance Definition at <http://www.sars.gc.ca>)  
 Hospital  Doctor's office  SARS case  Person with influenza-like illness  Other (specify): \_\_\_\_\_  
 Don't know

**Was the patient part of an organized tour?**  Yes  No  Don't Know  
**If yes**, type of tour:  Adoption  Tourism  Business  Other (specify): \_\_\_\_\_  
**If yes**, was the patient ill during tour?  Yes\*  No  Don't Know  
**If yes**, Name of tour/ tour company: \_\_\_\_\_ \*Contact CEPR (Office of Public Health Security) at Public Health Agency of Canada for tour group manifest.

**Was the patient ill during flight(s)?**  Yes\*\*  No  Don't Know  
**If yes**, specify flight number(s), carrier(s), seat number(s), city(s) of origin and date(s) of flight(s):

Flight # ***	Carrier	Seat #	City of origin	Date of Flight (dd/mm/yyyy)

\*\*Local public health units are to contact CEPR (Office of Public Health Security) at Public Health Agency of Canada for passenger manifest.  
 \*\*\* Connecting Flights and stop overs need to be assessed.

**BLOOD PRODUCTS**

**Did the patient receive a blood transfusion in the 10 days prior to onset of symptoms?**  Yes  No  Unknown  
**Did the patient donate blood after the onset of symptoms?**  Yes  No  Unknown  
**Did the patient donate blood in the 10 days prior to onset of symptoms?**  Yes  No  Unknown

**LABORATORY TESTING**  
 (refer to Laboratory Protocols at <http://www.sars.gc.ca>)

**SRI/SARS Laboratory Tracking Code:** SRI - \_\_\_\_\_ - \_\_\_\_\_  
 (Province/Territory) (Unique #)

Date Specimen Collected	Specimen Source	Test Method	Test Result	Date Test Performed

**COMMENTS:**  
 \_\_\_\_\_

**Note:** Pages 1 and 2 are to be completed and forwarded to the National SRI/SARS Reporting System, Public Health Agency of Canada. Personal contacts sheet(s) are NOT to be submitted to Public Health Agency of Canada.

Reporting Province/Territory: \_\_\_\_\_ Prov./Terr. SRI/SARS Case ID: \_\_\_\_\_

**SRI / SARS PERSONAL CONTACTS**

Please give details of all people with whom you have had close contact since the onset of your symptoms.  
 This includes people who:  
 1) live with you  
 2) work in the same environment as you  
 3) friends/family/others who have visited you/whom you have visited  
 4) other close contacts

Name of Contact (Last name, First name)	Phone Number	Type of Contact (please use above numbers)	Is this person ill with influenza-like or SRI/SARS-like illness?  If Yes, indicate Date of Onset (dd/mm/yyyy)
1			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
2			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
3			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
4			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
5			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
6			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
7			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
8			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
9			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
10			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
11			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
12			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
13			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
14			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
15			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
16			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
17			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
18			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
19			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
20			<input type="checkbox"/> Yes Onset: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know

If more contacts, please add in **SRI/SARS Contact Sheet** and staple to this form. Thank you.