

# Coronavirus Disease 2019 (COVID-19) Case Report Form

*Local health departments should submit this report to the regional health department.*

*Regional health departments should fax this report to 512-776-7616.*

Today's date \_\_\_\_\_

NNDSS local record ID/Case ID<sup>1</sup> \_\_\_\_\_

Case type:  Confirmed  Probable

Collected from (check all that apply):  Patient interview  Medical records

Patient's Name; First:		Middle:	Last:		Suffix:
Address:		City:	County:	State:	Zip Code:
Date of Birth: (MM/DD/YYYY)		Home Phone:	Cell Phone:	Email:	

STATE ID:	Date of Report:	City:	County:	State:
Investigator's name:	Phone:	Email:	Investigation Start Date:	
Physician's name:	Phone/Pager:			
Reporter's Name:	Phone:	Email:		

## PATIENT DEMOGRAPHIC INFORMATION

Sex:  M  F Age: \_\_\_\_\_  yr  mo  days

Race:  White  Black  Asian  Pacific Islander  Native American/Alaska Native  Unknown  Other: \_\_\_\_\_

Hispanic or Latino/a:  Yes  No  Unknown Residency:  U.S. resident  Non-U.S. resident, country: \_\_\_\_\_

## EXPOSURE INFORMATION

Residence Type:  Private residence  Homeless  Homeless shelter  Assisted living facility  Long term acute care

Long term care facility  Rehabilitation facility  Hospice  State Supported Living facility  Military base

Quarantine facility, military or other  Hotel  Jail  Prison  Detention Facility  Unknown

Other residence type: \_\_\_\_\_ Name of Facility if not private residence or homeless? \_\_\_\_\_

Occupation: \_\_\_\_\_  Unemployed  Student, Name of School: \_\_\_\_\_

### In the 14 days before symptom onset (or diagnosis date if asymptomatic), did the patient:

Have close contact<sup>3</sup> with a known COVID-19 case (confirmed or probable)?  Y  N  Unknown

Was the case ill at the time of contact?  Y  N  Unknown

Is the case a U.S. case?  Y  N  Unknown

Is the case an international case?  Y  N  Unknown

In which country was the case diagnosed with COVID-19? \_\_\_\_\_

Have no known exposure history (suspected community transmission)  Y  N  Unknown

Only check Y if you have been able to confirm that the patient has no exposure risk factors such as travel, contact with a confirmed or suspected case, providing care for a confirmed case, etc. If you are unable to ascertain exposure history, check Unknown.

Travel outside their city of residence?  Y  N  Unknown

If yes, list destinations and dates (MM/DD/YYYY)\* Date arrived Date left

1. \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

2. \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

3. \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

\*Please list any additional travel destinations or information in the comments section.

Is the patient a healthcare worker?  Y  N  Unknown

Provide care for a COVID-19 patient?  Y  N  Unknown

Is patient a member of a cluster of patients with severe acute respiratory illness (e.g., fever and pneumonia requiring hospitalization) of unknown etiology in which COVID-19 is being evaluated?  Y  N  Unknown

Is the patient associated with an outbreak?  Y  N  Unknown Outbreak Name(s)/Description \_\_\_\_\_

**DIAGNOSIS/CLINICAL INFORMATION**

Date of symptom onset \_\_\_\_\_  Asymptomatic Illness end date \_\_\_\_\_

Does the patient have the following signs and symptoms (check all that apply)?

- Fever<sup>2</sup>; Highest Measured Temperature \_\_\_\_\_°F  Cough  Sore throat  Shortness of breath  Chills  Headache  
 Muscle aches  Vomiting  Abdominal Pain  Diarrhea  New olfactory and taste disorder(s)  Loss of appetite  
 Fatigue or malaise  Runny nose  Wheezing  Chest pain  Other, Specify: \_\_\_\_\_

Co-morbid conditions (check all that apply):  None  Unknown  Pregnant; Due Date: \_\_\_\_\_  Diabetes

- Cardiac disease  Hypertension  Chronic pulmonary disease  Chronic kidney disease  Chronic liver disease  
 Immunosuppressive condition  Asthma  Hemoglobin disorders (e.g. sickle cell disease, thalassemia)  
 Severe Obesity (BMI ≥ 40)  Other, specify: \_\_\_\_\_

Is/was the patient: Hospitalized?  Y, Hospital name \_\_\_\_\_ Admit date \_\_\_\_\_  N

Discharged from hospital?  Y; Date of discharge \_\_\_\_\_  N

Admitted to ICU?  Y; Date admitted to ICU: \_\_\_\_\_  N Intubated?  Y  N  Unknown On ECMO?  Y  N  Unknown

On mechanical ventilation?  Y  N  Unknown If yes, total days on mechanical ventilation? \_\_\_\_\_

Diagnosis/Clinical Findings (select all that apply):

- Pneumonia (clinical or radiologic)  Y  N Acute respiratory distress syndrome  Y  N  
 Abnormal Chest X-ray?  Y  N  Unknown Abnormal EKG?  Y  N  Unknown

Patient died?  Y  N If yes, date of death: \_\_\_\_\_

Does the patient have another diagnosis/etiology for their respiratory illness?  Y, Specify \_\_\_\_\_  N  Unknown

Is the patient isolated at home?  Y  N

**Additional Comments** (smoking status, other comorbidities, potential contacts/places of exposure, etc.):

**LABORATORY RESULTS**

**RESPIRATORY DIAGNOSTIC RESULTS**

Test	Pos	Neg	Pending	Not done	Test	Pos	Neg	Pending	Not done
Influenza rapid Ag <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rhinovirus/enterovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza PCR <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coronavirus (OC43, 229E, HKU1, NL63)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>M. pneumoniae</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. metapneumovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>C. pneumoniae</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parainfluenza (1-4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other, Specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adenovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

**COVID-19 TESTING** (complete information for all that apply)

Test type	Specimen type	Specimen ID	Test Result	Date Collected	Date Resulted	Lab Type	Lab Name
<input type="checkbox"/> RNA/PCR <input type="checkbox"/> Serology <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> IgA <input type="checkbox"/> Viral culture <input type="checkbox"/> Rapid antigen <input type="checkbox"/> Other Specify:	<input type="checkbox"/> NP Swab <input type="checkbox"/> OP Swab <input type="checkbox"/> Serum/Blood <input type="checkbox"/> BAL fluid <input type="checkbox"/> Tracheal Aspirate <input type="checkbox"/> Sputum <input type="checkbox"/> Stool <input type="checkbox"/> Post-mortem, specify: <hr/> <input type="checkbox"/> Other, specify: <hr/>		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not done			<input type="checkbox"/> Public Health  <input type="checkbox"/> Commercial or Hospital	
<input type="checkbox"/> RNA/PCR <input type="checkbox"/> Serology <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> IgA <input type="checkbox"/> Viral culture <input type="checkbox"/> Rapid antigen <input type="checkbox"/> Other Specify:	<input type="checkbox"/> NP Swab <input type="checkbox"/> OP Swab <input type="checkbox"/> Serum/Blood <input type="checkbox"/> BAL fluid <input type="checkbox"/> Tracheal Aspirate <input type="checkbox"/> Sputum <input type="checkbox"/> Stool <input type="checkbox"/> Post-mortem, specify: <hr/> <input type="checkbox"/> Other, specify: <hr/>		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not done			<input type="checkbox"/> Public Health  <input type="checkbox"/> Commercial or Hospital	
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Additional test information:							

<sup>1</sup> For NNDSS reporters, use GenV2 or NETSS patient identifier.

<sup>2</sup> Fever may not be present in some patients, such as those who are very young, elderly, immunosuppressed, or taking certain medications. Clinical judgement should be used to guide testing of patients in such situations

<sup>3</sup> Close contact is defined as—

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a health care waiting area or room with a COVID-19 case

– or –

b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met”

See CDC’s updated guidance for infection control on their website for specific relevant guidance: <https://cdc.gov/coronavirus>

Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with 2019-nCoV (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to those exposed in health care settings.