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[1]**_____

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[3] 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 <u>has no exposure risk factors</u> 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[2]; 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

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

Has the patient received at least one dose of a COVID-19 vaccine? ☐ Y ☐ N ☐ Unknown

Has the patient received two doses of a COVID-19 vaccine? ☐ Y ☐ N ☐ Unknown

Vaccine manufacturer dose 1?:   ☐ Pfizer   ☐ Moderna   ☐ Other, Specify: _____

Date of dose 1 _____

Vaccine manufacturer dose 2 (if applicable)?:   ☐ Pfizer   ☐ Moderna   ☐ Other, Specify: _____

Date of dose 2 (if applicable): _____

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│ **Additional Comments** (list manufacturer and date of any additional COVID-19 vaccine doses): │
│   │
│   │
│   │
│   │
│   │
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LABORATORY RESULTS

RESPIRATORY DIAGNOSTIC RESULTS

Test	Pos	Neg	Pending	Not done	Test	Pos	Neg	Pending	Not done
Influenza rapid Ag ☐ A ☐ B	☐	☐	☐	☐	Rhinovirus/enterovirus	☐	☐	☐	☐
Influenza PCR ☐ A ☐ B	☐	☐	☐	☐	Coronavirus (OC43, 229E, HKU1, NL63)	☐	☐	☐	☐
RSV	☐	☐	☐	☐	*M. pneumoniae*	☐	☐	☐	☐
H. metapneumovirus	☐	☐	☐	☐	*C. pneumoniae*	☐	☐	☐	☐
Parainfluenza (1-4)	☐	☐	☐	☐	Other, Specify:	☐	☐	☐	☐
Adenovirus	☐	☐	☐	☐					

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	Sequencing Performed?

☐ RNA/PCR
☐ Serology
  ☐ IgM
  ☐ IgG
  ☐ IgA
☐ Viral culture
☐ Rapid antigen
☐ Sequencing
☐ Other Specify:
	☐ NP Swab
	☐ OP Swab
	☐ Serum/Blood
	☐ BAL fluid
	☐ Tracheal Aspirate
	☐ Sputum
	☐ Stool
	☐ Post-mortem, specify:
	_____
	☐ Other, specify:
	_____
			☐ Positive
			☐ Negative
			☐ Indeterminate
			☐ Not done
						☐ Public Health
						
						☐ Commercial or Hospital
								☐ Yes
								☐ No
								
								If yes, what GISAID [4] strain was reported, specify:
								_____
								
								Was a variant of concern identified?
								☐ B.1.1.7
								☐ B.1.351
								☐ Other, Specify:
								_____

☐ RNA/PCR
☐ Serology
  ☐ IgM
  ☐ IgG
  ☐ IgA
☐ Viral culture
☐ Rapid antigen
☐ Sequencing
☐ Other Specify:
	☐ NP Swab
	☐ OP Swab
	☐ Serum/Blood
	☐ BAL fluid
	☐ Tracheal Aspirate
	☐ Sputum
	☐ Stool
	☐ Post-mortem, specify:
	_____
	☐ Other, specify:
	_____
			☐ Positive
			☐ Negative
			☐ Indeterminate
			☐ Not done
						☐ Public Health
						
						☐ Commercial or Hospital
								☐ Yes
								☐ No
								
								If yes, what GISAID [4] strain was reported, specify:
								_____
								
								Was a variant of concern identified?
								☐ B.1.1.7
								☐ B.1.351
								☐ Other, Specify:
								_____

☐ RNA/PCR
☐ Serology
  ☐ IgM
  ☐ IgG
  ☐ IgA
☐ Viral culture
☐ Rapid antigen
☐ Sequencing
☐ Other Specify:
	☐ NP Swab
	☐ OP Swab
	☐ Serum/Blood
	☐ BAL fluid
	☐ Tracheal Aspirate
	☐ Sputum
	☐ Stool
	☐ Post-mortem, specify:
	_____
	☐ Other, specify:
	_____
			☐ Positive
			☐ Negative
			☐ Indeterminate
			☐ Not done
						☐ Public Health
						
						☐ Commercial or Hospital
								☐ Yes
								☐ No
								
								If yes, what GISAID [4] strain was reported, specify:
								_____
								
								Was a variant of concern identified?
								☐ B.1.1.7
								☐ B.1.351
								☐ Other, Specify:
								_____

Additional test information:								

[1]   *For NNDSS reporters, use GenV2 or NETSS patient identifier.*

[2]   *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*

[3]   *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.

[4] *The GISAID Initiative (https://www.gisaid.org/) serves as a standardized open source reference database that promotes the rapid sharing of genetic sequence data from the coronavirus causing COVID-19. This includes sequence and related clinical and epidemiological data associated with human viruses, to help researchers and public health professionals understand how the SARS-CoV-2 virus evolves and spreads during the ongoing pandemic. Additional genetic epidemiology resources can be found on the CDC's genomic epidemiology toolkit website (https://www.cdc.gov/amd/training/covid-19-gen-epi-toolkit.html).*