Form and checklist for confirmed COVID-19 patients

Sec PRV
Prim PRV

CL 45 TP Code 01 02 07 30 TP Code EPSDT 547 EPI Investigation (04) Group Services 19
AT____ TT_____ Medicaid #_____ POV Counsel POS COVID-19 (V01.79)
Health Center_____ HR#_____ Other POV _____

*Name of investigator:*_____ *Date test result received:*_____

Name of patient:_____ DOB:_____ Gender: _____

CDC ID number:_____ NBS number: _____

Minors: Guardian Name: _____ Guardian Job Status: ☐ Employed ☐ Unemployed ☐ Retired

Address:_____

Phone number(s):_____ Email:_____

Date and approximate time of symptom onset: _____ Infectious period start date:_____ (Onset – 2 days)

Initial symptoms: _____

Contact with a known case of COVID-19: Yes □ No □ Name:_____

Recent travel history? Yes □ No □ Location and date(s):_____

Recent contact with any visitors from another location? Yes □ No □ Location and date(s): _____

Patient reside in a congregate or LTCF? Yes □ No □ Name, address: _____

Does the patient have a thermometer? Yes □ No □ Does the patient have a mask? Yes □ No □

Last date of patient's isolation (a.k.a. infectious period end date):_____

↳ Persons **with COVID-19 who have symptoms** and were directed to care for themselves at home may discontinue home isolation under the following conditions:

- At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever- reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **AND**
- At least 10 days have passed *since symptoms first appeared*.

The following steps for each patient should be complete. Check-off when completed.

- ☐ Verify that hcp notified patient of test result
- ☐ Request medical records and patient demographic information from health care facility as needed
- ☐ Advise healthcare facilities where patient was seen to review infection control surrounding visit
- ☐ If applicable, patient advised on home isolation
- ☐ Interview patient
- ☐ If applicable, complete source investigation
- ☐ Contacts interviewed and emailed information
- ☐ Complete CDC PUI and Case Report Form as much as possible (prioritize variables on the first page) and return to Epi. For instructions for completing the case report form visit: https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID-19-Persons-Under-Investigation-and-Case-Report-Form-Instructions.pdf
- ☐ When available, send EPI contact line list with names, DOBs, and risk level
- ☐ Contact line list returned to Epi indicating that contacts have cleared from quarantine
- ☐ Patient provided with release from isolation letter, and last date of patient's isolation forwarded to Epi

 Provider Signature _____ **Date** _____

CDC 2019-nCoV ID: _____ Page____ of _____

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ____/_____/_____

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……

Human Infection with 2019 Novel Coronavirus Case Report Form

Reporting Jurisdiction		Case state/local ID	
Reporting Health Department		CDC 2019-nCoV ID	
Contact ID[a]		NNDSS loc. rec. ID/Case ID[b]	

[a]Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case CA102034567 has contacts CA102034567 -01 and CA102034567 -02. [b]For NNDSS reporters, use GenV2 or NETSS patient identifier.

Interviewer Information

Name of Interviewer: Last: First:	Telephone: Email:
Affiliation/Organization:	

Case Classification and Identification

What is the current status of this person?
☐ Lab-confirmed case* ☐ Probable case

If probable, select reason for case classification:
☐ Meets clinical criteria AND epidemiologic evidence with no confirmatory lab testing*
☐ Meets presumptive lab evidence± AND either clinical criteria OR epidemiologic evidence
☐ Meets vital records criteria with no confirmatory lab testing

*Detection of SARS-CoV-2 RNA in a clinical specimen using a molecular amplification detection test

± Detection of specific antigen in a clinical specimen, OR detection of specific antibody in serum, plasma, or whole blood indicative of a new or recent infection

Under what process was the case first identified? (check all that apply)
☐ Clinical evaluation ☐ Routine surveillance
☐ Contact tracing of case patient ☐ Other, specify: _____
☐ EpiX notification of travelers. If yes, DGMQID: _____
☐ Unknown

Report date of case to CDC (MM/DD/YYYY):
___/_____/_____

Date of first positive specimen collection (MM/DD/YYYY):
___/_____/_____ ☐ Unknown ☐ N/A

Hospitalization, ICU, and Death Information

Was the patient hospitalized?
☐ Yes ☐ No ☐ Unknown

If yes, admission date 1 ___/___/_____ (MM/DD/YYYY) discharge date 1 __/___/_____

If hospitalized, was a translator required?
☐ Yes ☐ No ☐ Unknown

If yes, specify which language: _____

Was the patient admitted to an intensive care unit (ICU)?
☐ Yes ☐ No ☐ Unknown

If yes, admission date 1 ___/___/_____ (MM/DD/YYYY) discharge date 1 __/___/_____

Did the patient die as a result of this illness?
☐ Yes ☐ No ☐ Unknown If yes, date of death (MM/DD/YYYY): ____/_____/_____ ☐ Unknown date

Case Demographics

Date of birth (MM/DD/YYYY): ____/_____/_____
Age: _____ Age units (yr/mo/day): _____
State of residence: ____ County of residence: _____
Does this case have any tribal affiliation? ☐ yes
Tribe name(s): _____ Enrolled member? ☐ yes

Sex:
☐ Male ☐ Other
☐ Female ☐ Unknown

If female, currently pregnant?
☐ Yes ☐ No ☐ Unknown

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Unknown

Race (check all that apply):
☐ Black ☐ White ☐ Asian
☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ Unknown ☐ Other, specify: _____

Which would best describe where the patient was staying at the time of illness onset?
☐ House/single family home ☐ Hotel/motel ☐ Nursing home/assisted living facility ☐ Rehabilitation facility ☐ Mobile home
☐ Apartment ☐ Long term care facility ☐ Acute care inpatient facility ☐ Correctional facility ☐ Group home
☐ Homeless shelter ☐ Outside, in a car, or other location not meant for human habitation ☐ Other (specify): _____ ☐ Unknown

Healthcare Worker Information

Is the patient a health care worker in the United States? ☐ Yes ☐ No ☐ Unknown

If yes, what is their occupation (type of job)?
☐ Physician ☐ Respiratory therapist ☐ Other, specify: _____
☐ Nurse ☐ Environmental services ☐ Unknown

If yes, what is their job setting?
☐ Hospital ☐ Rehabilitation facility ☐ Other, specify:_____
☐ Long-term care facility ☐ Nursing home/assisted living facility ☐ Unknown

Exposure Information

In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):

☐ Domestic travel (outside state of normal residence). Specify state(s): _____
☐ International travel. Specify country(s): _____
☐ Cruise ship or vessel travel as passenger or crew member. Specify name of ship: ____
☐ Workplace
If yes, is the workplace critical infrastructure (e.g., healthcare setting, grocery store)?
☐ Yes, specify workplace setting: _____ ☐ No ☐ Unknown
☐ Airport/airplane
☐ Adult congregate living facility (nursing, assisted living, or long-term care facility)
☐ School/university/childcare center
☐ Correctional facility
☐ Community event/mass gathering
☐ Animal with confirmed or suspected COVID-19. Specify animal: _____
☐ Other exposures, specify: _____
☐ Unknown exposures in the 14 days prior to illness onset

☐ Contact with a known COVID-19 case (probable or confirmed)

If the patient had contact with a known COVID-19 case:
What type of contact?
☐ Household contact
☐ Community-associated contact
☐ Healthcare-associated contact (patient, visitor, or healthcare worker)

Was this person a U.S. case?
☐ Yes, nCoV ID(s) _____, _____, _____
☐ No, this person was an international case and contact occurred abroad
☐ Unknown if U.S. or international case

Is this case part of an outbreak?
☐ Yes, specify outbreak name: _____ ☐ No ☐ Unknown

CDC 2019-nCoV ID: _____ Page____ of _____

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ____/_____/_____

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Human Infection with 2019 Novel Coronavirus Case Report Form

Clinical course, symptoms, past medical history, and social history

Collected from (check all that apply): ☐ Patient interview ☐ Medical record review

Symptoms present during course of illness:
- ☐ Symptomatic
- ☐ Asymptomatic
- ☐ Unknown

If case was symptomatic:

What was the onset date?
Onset date (MM/DD/YYYY): __/__/____
☐ Unknown symptom onset date

Did the patient's symptoms resolve?
Date of symptom resolution (MM/DD/YYYY): __/__/_____
- ☐ No, still symptomatic
- ☐ Symptoms resolved, unknown date
- ☐ Unknown if symptoms resolved

Did the patient develop pneumonia?
☐ Yes ☐ No ☐ Unknown

Did the patient have acute respiratory distress syndrome?
☐ Yes ☐ No ☐ Unknown

Did the patient have an abnormal chest X-ray?
☐ Yes ☐ No ☐ Unknown ☐ N/A, no chest X-ray done

Did the patient have another diagnosis/etiology for their illness?
☐ Yes ☐ No ☐ Unknown

Did the patient have an abnormal EKG?
☐ Yes ☐ No ☐ Unknown ☐ N/A, no EKG done

Did the patient receive mechanical ventilation (MV)/intubation?
☐ Yes ☐ No ☐ Unknown
If yes, total days with MV (days) _____

Did the patient receive ECMO?
☐ Yes ☐ No ☐ Unknown

If symptomatic, which of the following did the patient experience during their illness?

Fever >100.4F (38C)[c]	☐Yes	☐No	☐Unk	Cough (new onset or worsening of chronic cough)	☐Yes	☐No	☐Unk
Subjective fever (felt feverish)	☐Yes	☐No	☐Unk	Wheezing	☐Yes	☐No	☐Unk
Chills	☐Yes	☐No	☐Unk	Shortness of breath (dyspnea)	☐Yes	☐No	☐Unk
Rigors	☐Yes	☐No	☐Unk	Difficulty breathing	☐Yes	☐No	☐Unk
Muscle aches (myalgia)	☐Yes	☐No	☐Unk	Chest pain	☐Yes	☐No	☐Unk
Runny nose (rhinorrhea)	☐Yes	☐No	☐Unk	Nausea or vomiting	☐Yes	☐No	☐Unk
Sore throat	☐Yes	☐No	☐Unk	Abdominal pain	☐Yes	☐No	☐Unk
New olfactory and taste disorder(s)	☐Yes	☐No	☐Unk	Diarrhea (≥3 loose stools/24hr period)	☐Yes	☐No	☐Unk
Headache	☐Yes	☐No	☐Unk	Other, specify: _____, _____, _____	☐Yes	☐No	☐Unk
Fatigue	☐Yes	☐No	☐Unk				

Did they have any underlying medical conditions and/or risk behaviors? ☐Yes ☐No ☐Unknown

Diabetes Mellitus	☐Yes	☐No	☐Unk	Immunosuppressive condition	☐Yes	☐No	☐Unk
Hypertension	☐Yes	☐No	☐Unk	Autoimmune condition	☐Yes	☐No	☐Unk
Severe obesity (BMI ≥40)	☐Yes	☐No	☐Unk	Current smoker	☐Yes	☐No	☐Unk
Cardiovascular disease	☐Yes	☐No	☐Unk	Former smoker	☐Yes	☐No	☐Unk
Chronic Renal disease	☐Yes	☐No	☐Unk	Substance abuse or misuse	☐Yes	☐No	☐Unk
Chronic Liver disease	☐Yes	☐No	☐Unk	Disability (neurologic, neurodevelopmental, intellectual, physical, vision or hearing impairment) If yes, specify: _____	☐Yes	☐No	☐Unk
Chronic Lung disease (asthma/emphysema/COPD)	☐Yes	☐No	☐Unk				
Other chronic diseases If yes, specify: _____	☐Yes	☐No	☐Unk				
Other underlying condition or risk behavior, specify: _____	☐Yes	☐No	☐Unk	Psychological/psychiatric condition If yes, specify: _____	☐Yes	☐No	☐Unk

SARS-CoV-2 Testing (approved by FDA or other designated authority)

Test	Pos	Neg	Indet./Inconc.	Pend.	Not Done
Molecular amplification test (RT PCR)	☐	☐	☐	☐	☐
Serologic test	☐	☐	☐	☐	☐
Other (specify): _____	☐	☐	☐	☐	☐

Specimens for CoV-19 Testing

Specimen ID
1) _____
2) _____
3) _____

Additional Comments or Notes

COVID-19 Confirmed Case Investigation Worksheet

Patient Name (Last, First):	**CDC ID NUMBER:** **NBS (STATE) ID NUMBER:**
Patient Date of Birth:	**Physical Address/Current Patient Location:**
Current Sex: ☐ M ☐ F	**Phone:**

Reporting Hospital/Practice:	**Physician:**

Epidemiologic Information

Does the patient attend day care*? ☐Y ☐N ☐U
If yes, specify name of facility, location, and phone number(if available):_____

*Defined as a supervised group of 2 or more unrelated children for at least 4 hours per week

Does the patient reside in a congregate or long-term care facility? ☐Y ☐N ☐U
If yes, specify name of facility, location, and phone number(if available):_____

Has the patient had recent travel history? ☐Y ☐N ☐U
If yes, specify location and date(s): _____

Has the patient had recent contact with any visitors from another village/city/state? ☐Y ☐N ☐U
If yes, specify location and date(s): _____

Is the patient a contact to a known lab-confirmed COVID-19 Case? ☐Y ☐N ☐U

If yes, specify name, DOB, date(s) and nature of contact with confirmed case (if available):_____

_____

COVID-19 Confirmed Case Investigation Worksheet

History of Activity 2 Days Before and 7 Days After Symptom Onset

Instructions: include all locations that the patient may have visited outside their home for the period of interest. This includes daily activities like shopping, sports practice, work attendance and single events such as attendance at a party, fair, festival, etc. Please also ask about visitors to their home in this time frame. Use additional pages as needed to capture this information.

	Day	Date	Activities
INFECTIOUS PERIOD	-2		
	-1		
	0 (Illness onset)		
	1		
	2		
	3		
	4		
	5		
	6		
	7		
	8		
	9		
	10		***Use additional pages as needed to capture this information***

Completed by:_____ Phone:_____ Date:_____

COVID-19 Confirmed Case Investigation Worksheet

Summary of Contacts

*Name(s) of Investigator(s):*_____

Name of index patient:_____ DOB_____ Gender _____

Please provide risk assessment and instructions given from each contact form. Use additional sheets as needed.

Risk assessment categories: ***C****=Contact;* ***GP****=General Population*

Instruction categories: ***Q****=self-quarantine;* ***OBS****=self-observation*

Name	DOB	Risk Assessment	Phone Number	Type of Contact (work, household, etc.)	Instructions	Date of Last Exposure	End of 14 day period(if known)

CONTACT of confirmed case - (SOE 2019 COVID-19 PUI form PHN 4.27.2020)

Sec PRV						
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CL 45 TP Code 01 02 07 30 TP Code EPSDT 547 EPI Investigation (04) Group Services 19
AT_____TT_____ Medicaid #_____ POV Counsel Contact COVID-19 (V01.79)

Health Center_____ HR#_____ Other POV _____

Insurance Type: ☐ Medicaid ☐ Medicare ☐ Tricare ☐ Other Private Insurance ☐ Uninsured/Tribal

Race (check all that apply): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White

Number in Household _____ - Household Income (before taxes) per month _____ - Hispanic? ☐ Yes ☐ No

Investigator Name:_____Interview date: _____

Name of contact:_____**DOB:**_____**Gender:** _____

Minors: Guardian Name:_____ Guardian Job Status: ☐ Employed ☐ Unemployed ☐ Retired

Address:_____

Phone number(s):_____Email:_____

Name of index case:_____Case Infectious period start date:_____(2 days before symptom onset)

Date of contact's most recent exposure to index case while index case was infectious: _____

Nature of contact with the index case (Describe)

Household member Yes ☐ No ☐ Intimate partner Yes ☐ No ☐

Individual providing care in the household without using recommended infection control precautions Yes ☐ No ☐

Individual who had close contact (< 6 feet)** for a prolonged period of time (current definition >10 minutes) Yes ☐ No ☐

Other (e.g., someone who was coughed on by case): Yes ☐ No ☐ If yes, describe?_____

_____

- Is contact with the index case ongoing (e.g. household contact or caregiver)? Yes ☐ No ☐
- Does the contact have current/recent (past 2 weeks) history of fever or respiratory symptoms? Yes ☐ No ☐
- If symptomatic, was the contact referred for testing? Yes ☐ No ☐
- Does the contact have a thermometer? Yes ☐ No ☐
- Does the contact have a mask (to be worn if symptomatic)? Yes ☐ No ☐

Remind all contacts to call ahead to a provider and tell the provider they are a contact before seeking care.

Risk Assessment (circle one): Contact (if yes to any of the questions in the 'Nature of Contact box' above)
General Population-level Risk

Instructions Given* (circle one): Self-quarantine/ General guidance

Additional information will be needed for contacts who are health care providers.

Quarantine / monitoring period ends (14 days after last contact with index case) (NOTE: those with ongoing case may need to restart their 14 days when the case is released from isolation.)

Contact cleared date (if known):_____

Checklist:

- Contact emailed / faxed information sheet: Yes ☐ No ☐
- Information submitted to relevant PHN: Yes ☐ No ☐
- Contact entered into NBS: Yes ☐ No ☐

** Factors to consider when defining close contact include proximity, the duration of exposure (e.g., longer exposure time likely increases exposure risk), whether the case had symptoms (e.g., coughing likely increases exposure risk) and whether the individual was wearing a facemask (which can efficiently block respiratory secretions from contaminating others and the environment).

COVID-19 Confirmed Case Investigation Worksheet

Source Investigation To be completed if suspected community transmission

Days prior to symptom onset:

DAY	**Instructions include all locations that the patient may have visited outside their home for the period of interest. This includes daily activities like shopping, sports practice, work attendance and single events such as attendance at a party, fair, festival, etc. Please ask about visitors to their home. Use additional pages as necessary.**
-1	
-2	
-3	
-4	
-5	
-6	
-7	
-8	
-9	
-10	
-11	
-12	
-13	
-14	

Completed by: Phone: _ _ Date: _ _