

.....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

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

^aOnly 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. ^bFor 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 hospitalized, was a translator required?
 Yes No Unknown

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

If yes, admission date 1 _____ discharge date 1 _____
If yes, specify which language: _____
If yes, admission date 1 _____ 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

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: _____

If female, currently pregnant?
 Yes No Unknown

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

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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:		If case was symptomatic:	
<input type="checkbox"/> Symptomatic		What was the onset date?	Did the patient's symptoms resolve?
<input type="checkbox"/> Asymptomatic		Onset date (MM/DD/YYYY): ___/___/___	Date of symptom resolution (MM/DD/YYYY): ___/___/___
<input type="checkbox"/> Unknown		<input type="checkbox"/> Unknown symptom onset date	<input type="checkbox"/> No, still symptomatic
			<input type="checkbox"/> Symptoms resolved, unknown date
			<input type="checkbox"/> Unknown if symptoms resolved
Did the patient develop pneumonia?		Did the patient have an abnormal EKG?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A, no EKG done	
Did the patient have acute respiratory distress syndrome?		Did the patient receive mechanical ventilation (MV)/intubation?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Did the patient have an abnormal chest X-ray?		If yes, total days with MV (days) _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A, no chest X-ray done		Did the patient receive ECMO?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Did the patient have another diagnosis/etiology for their illness?			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

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

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

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

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

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

Test	Pos	Neg	Indet./Incon.	Pend.	Not Done
Molecular amplification test (RT PCR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serologic test	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>

Specimens for CoV-19 Testing

Specimen ID
1) _____
2) _____
3) _____

Additional Comments or Notes