Patient first name		CDC 2019-nCoV ID):				
PATENT I DENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC. Human Infection with 2019 Novel Coronavirus Case Report Form		PATIENT IDENTIFIER INFORMATION	I IS NOT TRANS	MITTED TO CDC			
PATENT I DENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC. Human Infection with 2019 Novel Coronavirus Case Report Form	Patient first	name Patient last name		Date of birth (MM/I	DD/YYYY): / /		
Reporting Jurisdiction	and security for						
Reporting Jurisdiction	/ // yan		IIS NOT TRANS	MITTED TO CDC	••••••		
Reporting Jurisdiction Case state/local ID Reporting Health Department CDC 2019-nCoV ID Reporting Health Department CDC 2019-nCoV ID Contract ID* NNSSS Io. Free Lip/Case ID* NNSSS Io. Free Lip/Case ID* NNSSS Io. Free Lip/Case ID* NNSS Io. Free Lip/Case ID*	1 2 C	Human Infection wi	th 2019 N	lovel Coronav	virus		
Reporting fursidiction Case state/local ID	Marega C	(A. 700) (100)			711 43		
Reporting Health Department		Case	Keport F	Orm			
Reporting Health Department		T	_	*****			
Contact IDP			Case state/	ocal ID	×		
Control trace-pulser is a town created of pier some case points. Assign Contact Dusing CCC 2019 + (20.VTD and sequential centers 10, e.g., Confirmed ass CL100204667 As and Accidentable (AL00204667 All and CL100204667 All and CL10020467 All a			CDC 2019-n	CoV ID			
Caccessification and identification							
Interviewer Information	Only complete if case-patient is a known contact	t of prior source case-patient. Assign Contact ID using CDC 2019-nC	CoV ID and sequentia	I contact ID, e.g., Confirmed cas	e CA102034567 has contacts CA102034567 -01 and		
Name of Interviewer: Last: First: Telephone: Email:		1V2 or NE133 patient identifier.					
Affiliation/Organization:		Circt.	Tolombono		FII		
Case Classification and identification		FIISC:	relephone:		Email:		
Was the current status of this person? Lab-confirmed case* Probable case Under what process was the case first identified? (check all that apply) Clinical evaluation Routine surveillance Clinical evaluation Clinical evaluation Routine surveillance Clinical evaluation Routine surveillance Clinical evaluation Clinical	Affiliation/Organization:						
Clinical evaluation Routine surveillance If probable, select reason for case classification: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation of travelers. If yes, Odd(Ot): Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation Contact trading of case patient Other, specify: Clinical evaluation of travelers. If yes, date of death (MM/DD/YYY): Clinical evaluation of travelers. If yes, date of death (MM/DD/YYY): Clinical evaluation of travelers. If yes, other contact inding of case patient Other, specify: Clinical evaluation of travelers. If yes, other contact indination of travelers. If yes, other case is not yes of the case of the contact indination of travelers. If yes, other case is not yes, and is not at a clinical year and incitive Other, specify: Clinical y	Case Classification and Ident	ification					
If probable, select reason for case classification:	What is the current status of this per-	son?		Under what process w	as the case first identified? (check all that apply)		
Meets clinical criteria AND epidemiologic evidence with no confirmatory lab testing* EpiX notification of travelers. If yes, DGMQID: Heets presumptive lab evidence* AND epidemiologic evidence Meets virtal records criteria with no confirmatory lab testing Detection of SARS-CoV-2 RNA in a clinical specimen, OR detection of specific antiponic and clinical specimen, OR detection of specific antiponic plants, or whole blood indicative of a new or recent infection Morphysiolary Detection of specific antiponic plants, or whole blood indicative of a new or recent infection Morphysiolary Detection of Sarah, or whole blood indicative of a new or recent infection Morphysiolary Detection of Sarah, or whole blood indicative of a new or recent infection Was the patient hospitalized? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care unit (ICU)? Was the patient admitted to an intensive care	Lab-confirmed case* Prob	pable case		☐ Clinical evaluation	☐ Routine surveillance		
Meets clinical criteria AND epidemiologic evidence with no confirmatory lab testing* Meets presumptive lab evidence* AND either clinical criteria or Repidemiologic evidence Meets vital records criteria with no confirmatory lab testing Osteocitor 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 antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen, OR detection of specific antigen in a clinical specimen collection of specif	If probable, select reason for case cla	ssification:					
Meets vital records criteria with no confirmatory lab testing	The state of the s			EpiX notification of	f travelers. If yes, DGMQID:		
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, Date of first positive specimen collection (MM/DD/YYYY): Date of MADE o			ence	Unknown			
Date of first positive specimen collection (MM/DD/YYYY): Date of first positive specimen collection (MM/DD/YYYY): Date of first positive specimen collection (MM/DD/YYYY): Unknown N/A				Report date of case to	CDC (MM/DD/YYYY):		
Disama, or whole blood indicative of a new or recent infection							
Hospitalization, ICU, and Death Information Hospitalized, was a translator required? Was the patient admitted to an intensive care unit (ICU)? Yes	1		in serum,	/ / /	Unknown DN/A		
Was the patient hospitalized? If hospitalized, was a translator required? Yes No Unknown Yes Yes No Unknown Yes Yes No Unknown Yes Yes Sex Yes							
Yes							
If yes, admission date 1							
MM/DD/YYYY							
Did the patient die as a result of this illness? Yes No Unknown If yes, date of death (MM/DD/YYYY):		in feet and a second se					
Date of birth (MM/DD/YYY):		illness?					
Date of birth (MM/DD/YYYY):	Yes No	Unknown If yes, date of death (MM/DD/Y	YYY):/	/	date		
Date of birth (MM/DD/YYYY):	Fase Demographics	1					
Age Age units (yr/mo/day):		/ Sev	Ethnici	tu: Pa	co (chock all that apply).		
State of residence:							
Does this case have any tribal affiliation? yes					American Indian/Alaska Native		
Tribe name(s):			? Uı	nknown	Native Hawaiian/Other Pacific Islander		
House/single family home Hotel/motel Nursing home/assisted living facility Correctional facility Group home Homeless shelter Outside, in a car, or other location not meant for human habitation Other (specify): Unknown Homeless shelter Outside, in a car, or other location not meant for human habitation Other (specify): Unknown Healthcare Worker Information			iown		Unknown Other, specify:		
Apartment	Which would best describe where the	e patient was staying at the time of illness onset?					
Homeless shelter				Rehabilitation	facility		
Is the patient a health care worker in the United States? Yes No Unknown				Name of the last o	,		
Is the patient a health care worker in the United States? Yes No Unknown If yes, what is their occupation (type of job)? If yes, what is their job setting? Physician Respiratory therapist Other, specify: Hospital Rehabilitation facility Other, specify: Unknown Long-term care facility Nursing home/assisted living facility Unknown Unk	Homeless shelter U O	utside, in a car, or other location not meant for hu	man habitation	U Other (specify)): Unknown		
Is the patient a health care worker in the United States? Yes No Unknown If yes, what is their occupation (type of job)? If yes, what is their job setting? Physician Respiratory therapist Other, specify: Hospital Rehabilitation facility Other, specify: Unknown Long-term care facility Nursing home/assisted living facility Unknown Unk	Healthcare Worker Informati	ion					
Physician Respiratory therapist Other, specify: Hospital Rehabilitation facility Other, specify: Unknown Long-term care facility Nursing home/assisted living facility Unknown	Is the patient a health care worker in	the United States? Yes No Unkno	wn				
Nurse	If yes, what is their occupation (type	of job)?	If yes, what is	their job setting?			
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): Contact with a known COVID-19 case (probable or confirmed) International travel. Specify country(s): If the patient had contact with a known COVID-19 case: What type of contact? Workplace If yes, is the workplace critical infrastructure (e.g., healthcare setting, grocery store)? Household contact Community-associated contact Healthcare-associated contact (patient, visitor, or healthcare worker) Adult congregate living facility (nursing, assisted living, or long-term care facility) Was this person a U.S. case? Yes, nCoV ID(s),,	Theriabilitation facility Collect, specify.						
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):	Nurse Environmental	services Unknown	☐ Long-term	care facility \[\square \text{Nursin}	ng home/assisted living facility 🔲 Unknown		
Domestic travel (outside state of normal residence). Specify state(s):	Exposure Information						
International travel. Specify country(s): If the patient had contact with a known COVID-19 case: What type of contact? What type of contact? Household contact Household contact Household contact Healthcare setting: No	In the 14 days prior to illness onset, d	lid the patient have any of the following exposures	(check all that	apply):			
International travel. Specify country(s): If the patient had contact with a known COVID-19 case: What type of contact? What type of contact? Household contact Household contact Household contact Healthcare setting: No							
Workplace If yes, is the workplace critical infrastructure (e.g., healthcare setting, grocery store)? What type of contact? Household contact Community-associated contact Healthcare-associated contact Healthcare-associated contact What type of contact? Household contact Community-associated contact Healthcare-associated contact What type of contact? Household contact Community-associated contact What type of contact? Healthcare worker Was this person a U.S. case? What type of contact? Household contact Community-associated contact Was this person a U.S. case? Yes, nCoV ID(s) Yes, nCoV ID(International travel. Specify country(s):						
Household contact Community-associated contact Healthcare setting, grocery store)? Household contact Community-associated contact Healthcare-associated contact Healthcare-associated contact Healthcare setting; Household contact Community-associated contact Healthcare-associated contact Healthcare worker) Household contact Community-associated contact Healthcare-associated contact Healthcare setting; Household contact Community-associated contact Household contact Healthcare setting; Household contact Hou		Cruise ship or vessel travel as passenger or crew member. Specify name of ship:					
Yes, is the workplace critical limitstructure (e.g., neathcare setting, grocery store)? Yes, specify workplace setting:	□ workplace						
Airport/airplane Adult congregate living facility (nursing, assisted living, or long-term care facility) School/university/childcare center Healthcare-associated contact (patient, visitor, or healthcare worker) Was this person a U.S. case? Yes, nCoV ID(s),	Yes, specify workplace setting	tion in the state (e.g., realitically setting, grocery store)	"	Community-associated			
Adult congregate living facility (nursing, assisted living, or long-term care facility) School/university/childcare center Was this person a U.S. case? Yes, nCoV ID(s)		- Line Conknown		Healthcare-associated	contact (patient, visitor, or healthcare worker)		
School/university/childcare center	Adult congregate living facility (nu	ursing, assisted living, or long-term care facility)			e?		
☐ Correctional facility ☐ No, this person was an international case and contact occurred abroad	☐ School/university/childcare cente	School/university/childcare center					
☐ Community event/mass gathering ☐ Unknown if U.S. or international case		g	- Comments		1		

Is this case part of an outbreak?

Yes, specify outbreak name:

☐ No

Unknown

Other exposures, specify:

Animal with confirmed or suspected COVID-19. Specify animal:

Unknown exposures in the 14 days prior to illness onset

CDC 2019-nCoV ID:								
PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC								
→ Patient first name		Patien	t last name	Date of birth (MM/DD/YYYY):	/	_/		
adult season to	PATIENT	IDENTIFIE	R INFORMA	ATION IS NOT TRANSMITTED TO CDC				
((CDC								
dearest our bearing and bearin	Hur	man in		with 2019 Novel Coronavirus				
			Ca	se Report Form				
linical course, symptoms, past me	dical hist	ory, and	social hi	story				
Collected from (check all that apply):				dical record review				
Symptoms present during course of illness:		If case wa	as symptom	natic:				
Symptomatic			s the onset			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, ,	
Asymptomatic				/YYYY):/ Date of symptom resolution (MM, on onset date	יושטיי	****):		-
Unknown		☐ Unkno	own sympto	om onset date	n date	9		
9				Unknown if symptoms resolve				
Did the patient develop pneumonia?				Did the patient have an abnormal EKG? ☐ Yes ☐ No ☐ Unknown ☐ N/A,	no Ek	'G don	9	
Yes No Unknown							C	
Did the patient have acute respiratory distress syndrome? □ Ves □ No □ Unknown □ Yes □ No □ Unknown								
	Yes No Unknown If yes, total days with MV (days)							
	Did the patient have an abnormal chest X-ray?							
	- 151 1.51		one	Yes No Unknown	1			
Did the patient have another diagnosis/etiology Yes No Unknown	gy for their i	liness?						
Tes No Gentiloui								
If symptomatic, which of the following	ng did th	e patient	experier	nce 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	1 =	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 □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)	\vdash \sqcup	res	Пио	Попк
Headache	Yes	No	Unk	Other, specify:		Yes	□No	Unk
Fatigue	Yes	No	Unk					
Did they have any underlying medic	al conditi	ions and	or risk b	ehaviors? 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				
Chronic Lung disease	□ves		□Unk	(neurologic, neurodevelopmental, intellectual,	_	1		

physical, vision or hearing impairment)

Psychological/psychiatric condition

If yes, specify:

If yes, specify:

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):					

Yes

Yes

Yes

No

No

No

Unk

Unk

Unk

Specimens for CoV-19 Testing

Sp	ecimen ID
1)	
2)	-
3)	

Yes

Yes

□No

□No

Unk

Unk

Additional Comments or Notes

(asthma/emphysema/COPD)

Other underlying condition or risk

Other chronic diseases

If yes, specify:

behavior, specify:

Clinical