Priority information

CDC 2019-nCoV ID: ____________

……………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]	

[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

Was this case lost to follow up?
☐ Yes ☐ No ☐ Unknown

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 ☐ Unknown
☐ Non-Hispanic/Latino
Primary language: ________________

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)
☐ K-12 school Name:_________________________ Role:_______________
☐ College/university Name: ________________________ Role:_______________
☐ Childcare center Name: _________________________ Role:_______________
☐ Correctional facility
☐ Community event/mass gathering
☐ Animal with confirmed or suspected COVID-19. Specify animal: _______

☐ 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
☐ Other exposures, specify: ___________
☐ Unknown exposures in the 14 days prior to illness onset

CDC 2019-nCoV ID: ☐

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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:
☐ 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

Was the disclosure authorized by the case or their guardian?
☐ Yes, obtained written HIPAA Authorization Form
☐ HIPAA Exception, no authorization obtained (uncooperative case/ guardian)
☐ HIPAA Exception, obtained verbal authorization
☐ HIPAA Exception, no authorization obtained (unable to reach case/guardian)

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

Symptom			
Fever >100.4F (38C)[c]	☐ Yes	☐ No	☐ Unk
Subjective fever (felt feverish)	☐ Yes	☐ No	☐ Unk
Chills	☐ Yes	☐ No	☐ Unk
Rigors	☐ Yes	☐ No	☐ Unk
Muscle aches (myalgia)	☐ Yes	☐ No	☐ Unk
Runny nose (rhinorrhea)	☐ Yes	☐ No	☐ Unk
Nasal congestion	☐ Yes	☐ No	☐ Unk
Sore throat	☐ Yes	☐ No	☐ Unk
Loss of taste	☐ Yes	☐ No	☐ Unk
Loss of smell	☐ Yes	☐ No	☐ Unk
Headache	☐ Yes	☐ No	☐ Unk
Fatigue	☐ Yes	☐ No	☐ Unk
Cough (new onset or worsening of chronic cough)	☐ Yes	☐ No	☐ Unk
Wheezing	☐ Yes	☐ No	☐ Unk
Shortness of breath (dyspnea)	☐ Yes	☐ No	☐ Unk
Difficulty breathing	☐ Yes	☐ No	☐ Unk
Persistent pain or pressure in the chest	☐ Yes	☐ No	☐ Unk
Nausea	☐ Yes	☐ No	☐ Unk
Vomiting	☐ Yes	☐ No	☐ Unk
Abdominal pain or tenderness	☐ Yes	☐ No	☐ Unk
Diarrhea (≥3 loose stools/24hr period)	☐ Yes	☐ No	☐ Unk
Confusion or change in mental status	☐ Yes	☐ No	☐ Unk
Pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone	☐ Yes	☐ No	☐ Unk
Inability to wake or stay awake	☐ Yes	☐ No	☐ Unk
Other, specify: ______________	☐ Yes	☐ No	☐ Unk

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

Condition			
Diabetes Mellitus	☐ Yes	☐ No	☐ Unk
Hypertension	☐ Yes	☐ No	☐ Unk
Severe obesity (BMI ≥40)	☐ Yes	☐ No	☐ Unk
Cardiovascular disease	☐ Yes	☐ No	☐ Unk
Chronic Renal disease	☐ Yes	☐ No	☐ Unk
Chronic Liver disease	☐ 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
Immunosuppressive condition	☐ Yes	☐ No	☐ Unk
Autoimmune condition	☐ Yes	☐ No	☐ Unk
Current smoker	☐ Yes	☐ No	☐ Unk
Former smoker	☐ Yes	☐ No	☐ Unk
Substance abuse or misuse	☐ Yes	☐ No	☐ Unk
Disability (neurologic, neurodevelopmental, intellectual, physical, vision or hearing impairment) If yes, specify: ______________	☐ Yes	☐ No	☐ Unk
Psychological/psychiatric condition If yes, specify: ______________	☐ Yes	☐ No	☐ Unk

Vaccination

Did the patient ever receive COVID-19 vaccine?
☐ Yes
☐ No
☐ Unknown

Vaccination doses prior to onset: _______
Date of last dose prior to illness onset:
______/_______/________

Vaccine History Comments

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