

nCoV ID:

Form Approved: OMB: 0920-XXXX Exp. X/XX/XXXX

.....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.....



COVID-19 Case Investigation 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. For NNDSS reporters, use GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Last _____ First _____

Affiliation/Organization: _____

Telephone _____ Email _____

Date of interview: _____ (MM/DD/YYYY) Date of medical chart abstraction: _____ (MM/DD/YYYY)

Data sources used for this form?

Case-patient interview Other interview, specify relationship to case: _____ Medical Chart Abstraction

Case-patient's primary language: _____ Was this form administered via a translator? Yes No Unknown

Case-patient demographic information

- Report date to CDC (MM/DD/YYYY): ____/____/____
- Under what process was the case first identified? (check all that apply): PUI/sought care for acute illness Contact tracing of case patient Surveillance system, please specify: _____
 EpiX notification of travelers; if checked, DGMQID _____ Unknown Other, specify: _____
- Date of birth (month and year): Month ____ Year ____
- Age: _____ Age units: Years Months Days
- Sex: Male Female
- Ethnicity: Hispanic/Latino Non-Hispanic/Latino Not specified
- Race (check all that apply): White Asian American Indian/Alaska Native Black
 Native Hawaiian/Other Pacific Islander Unknown Other, specify: _____
- County of Residence: _____ State of Residence: _____
- Country of Residence: United States Other, specify _____
- Occupation: _____
If student, what grade level? _____
If child, does s/he attend day care? Yes No Unknown

Travel history

- In the 14 days prior to illness onset, were you traveling away from your home internationally?
 Yes No Unknown
- In the 14 days prior to illness onset, were you traveling away from your home within the United States?
 Yes No Unknown
- Where did you travel 14 days prior to illness onset (list **ALL** locations, including overnight transits and layovers)?

	Departure Date (MM/DD/YYYY)	Departure city, state/province/country	Arrival Date (MM/DD/YYYY)	Arrival city, state/province/country
Trip 1				
Trip 2				



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Trip 3			
Trip 4			
Trip 5			

Exposure history

14. In the **14 DAYS prior to illness**, did you have close contact with another lab-confirmed COVID-19 case-patient?

Yes No Unknown Date Range: Start Date (MM/DD/YYYY) _____ End Date (MM/DD/YYYY) _____

15. Relationship to COVID-19 **source** case (select all that apply):

Spouse/Partner Child Parent Other Family Friend HCW Co-worker
 Classmate Roommate Contact only - no relationship Other (specify): _____

16. Exposure setting to the COVID-19 **source** case (select all that apply):

Household Work Daycare School/University Transit Rideshare Hotel Cruise Ship
 Healthcare Other (specify): _____

17. In the **14 DAYS prior to illness onset**, did you:

Exposure	Answer	Date Range
...have any household members, friends, acquaintances, or co-workers who had fever or respiratory symptoms (e.g. cough, sore throat etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
...have close contact (e.g. caring for, speaking with, or touching) with any ill persons?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
...attend a mass gathering (e.g., religious event, wedding, party, dance, concert, banquet, festival, sports event, or other event)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
...use public transportation (bus, train, airplane)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
...attend or work at a school or daycare?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
...have a household member who attended school or daycare?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
...have close contact (e.g. caring for, speaking with, or touching) with a sick person who had contact with a COVID-19 patient (i.e., secondary contact to confirmed case)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
...have close contact (e.g. caring for, speaking with, or touching) with a person who had a fever and/or acute respiratory illness and international travel in the past 2 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes where did the person travel: _____	

18. In the **14 DAYS prior to illness onset**, did you:

Exposure	Y/N/Unk	Facility type (Select all that apply)	Date(s) exposure occurred
Work in healthcare setting:	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk If yes, what was your role: <input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Administration	<input type="checkbox"/> Hospital <input type="checkbox"/> Dialysis unit/center <input type="checkbox"/> Urgent Care <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Doctor's office/clinic <input type="checkbox"/> Other (specify)	

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	staff <input type="checkbox"/> Housekeeping <input type="checkbox"/> Patient transport <input type="checkbox"/> Other, specify _____		
Volunteer in healthcare setting	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Hospital <input type="checkbox"/> Urgent Care <input type="checkbox"/> Doctor's office/clinic	<input type="checkbox"/> Dialysis unit/center <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Other (specify)
Have direct patient contact	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Hospital <input type="checkbox"/> Urgent Care <input type="checkbox"/> Doctor's office/clinic	<input type="checkbox"/> Dialysis unit/center <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Other (specify)
Visit healthcare setting as a patient (not just for this illness)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Hospital <input type="checkbox"/> Urgent Care <input type="checkbox"/> Doctor's office/clinic	<input type="checkbox"/> Dialysis unit/center <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Other (specify)
Visit healthcare setting for any reason other than as a patient	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Hospital <input type="checkbox"/> Urgent Care <input type="checkbox"/> Doctor's office/clinic	<input type="checkbox"/> Dialysis unit/center <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Other (specify)
Contact with a known COVID-19 case-patient in a healthcare setting	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk If yes, as a <input type="checkbox"/> Patient <input type="checkbox"/> Visitor <input type="checkbox"/> HCW	<input type="checkbox"/> Hospital <input type="checkbox"/> Urgent Care <input type="checkbox"/> Doctor's office/clinic	<input type="checkbox"/> Dialysis unit/center <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Other (specify)

19. Do you reside in an institutional or group setting (e.g. long-term care facility/nursing home, boarding school, college dormitory, etc.)?

Yes No Unknown

20. How many people in total resided in your household (HH) from the 14 days prior to illness through the date of this interview (excluding you)? _____ . A household member is anyone with at least one overnight stay during the 14 days prior to patient's illness onset to the date of this interview. If patient belongs to multiple HH, group HH members by identifying the 1st HH as A, the 2nd HH as B, etc.

HH (if case-patient belongs to >1 HH)	Relation to patient	Sex M/F	Age (specify unit as years, months, or days)	Did household member have fever or respiratory symptoms (e.g. cough, sore throat, etc.) in the 14 days prior to patient's illness onset, during the patient's illness, or 14 days after patient's illness?	Date of illness onset of household member (MM/DD/YYYY)
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	

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HH (if case-patient belongs to >1 HH)	Relation to patient	Sex M/F	Age (specify unit as years, months, or days)	Did household member have fever or respiratory symptoms (e.g. cough, sore throat, etc.) in the 14 days prior to patient's illness onset, during the patient's illness, or 14 days after patient's illness?	Date of illness onset of household member (MM/DD/YYYY)
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	

Symptoms

21. If symptomatic, onset date of first symptom (MM/DD/YYYY): ___/___/___ Unknown Asymptomatic
22. If experienced symptoms, are you Still symptomatic Unknown symptom status Symptoms resolved
 If symptoms resolved, date of symptom resolution (MM/DD/YYYY): ___/___/___ Unknown date
23. During this illness, did you experience any of the following symptoms?

Symptom		Symptom	
Fever $\geq 100.4F$ (38C)	<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
Highest temp _____ °F		Dry	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Date of onset (MM/DD/YYYY) ___/___/___		Productive	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Duration of fever $\geq 100.4F$ (38C) (days) _____		Bloody sputum (hemoptysis)	<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	Shortness of breath (dyspnea)	<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	Wheezing	<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	Chest Pain	<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	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Vomiting	<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	Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Eye redness (conjunctivitis)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diarrhea (≥ 3 loose/looser than normal stools/24hr period)	<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	Poor Feeding/Poor appetite	<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	Seizures	<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	Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Past medical history

24. Do you have any pre-existing medical conditions? Yes No Unknown

Chronic Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Asthma/reactive airway disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Emphysema/COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Other chronic lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(If YES, specify) _____
Active tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	



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Diabetes Mellitus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Cardiovascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Coronary artery disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Heart failure/Congestive heart failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Cerebrovascular accident/Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Congenital heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Renal disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Chronic kidney disease/insufficiency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
End-stage renal disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Dialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Alcoholic hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Chronic liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Cirrhosis/End stage liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Hepatitis B, chronic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Hepatitis C, chronic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Non-alcoholic fatty liver disease (NAFLD)/NASH	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Immunocompromised Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
HIV infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
AIDS or CD4 count <200	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Solid organ transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Stem cell transplant (e.g., bone marrow transplant)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Cancer: current/in treatment or diagnosed in last 12 months	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Immunosuppressive therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____ _____ For what condition: _____
Neurologic/neurodevelopmental disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Other chronic diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____

25. Current height: _____ (inches) OR _____ (cm)
26. Current weight: _____ (pounds) OR _____ (kg)
27. If female, are you currently pregnant? Yes Weeks pregnant at illness onset _____ No Unknown
28. If female, are you postpartum (≤ 6 weeks postpartum)? Yes No Unknown
29. If female, are you breastfeeding? Yes No Unknown
30. If child, is he/she being breastfed? Yes No Unknown

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Social history

- 31. Do you currently smoke cigarettes? Yes No Unknown
If yes, how many packs of cigarettes per day? _____ For how many years? _____
- 32. Have you ever smoked cigarettes? Yes No Unknown
If yes, how many packs of cigarettes per day? _____ For how many years? _____ How long since you last smoked a cigarette? ___(m) ___(y)
- 33. Do you currently use e-cigarettes/vape-pen? Yes No Unknown
- 34. In the past year, how often did you have a drink containing alcohol?
• Never • Monthly or less • 2-4 times a month • 2-3 times per week • 4 or more times per week

Course of Illness

- 35. Do you feel back to normal? Yes No Not applicable (patient deceased) Not applicable (patient asymptomatic)
 Unknown
If yes, when did you feel back to normal? ____/____/____ (MM/DD/YYYY)
- 36. Did you miss work or school for this illness? Yes No Unknown
If yes, how many days during illness? _____
- 37. Did you receive any medical care for the illness? Yes No Unknown
- 38. If yes, where and which dates did you seek care after this illness started (check all that apply)? [Please add extra visit dates in 'notes' box]
 - Doctor's office Date 1: ____/____/____ (MM/DD/YYYY) Date 2: ____/____/____ (MM/DD/YYYY)
 - Emergency room Date 1: ____/____/____ (MM/DD/YYYY) Date 2: ____/____/____ (MM/DD/YYYY)
 - Retail store/pharmacy Date 1: ____/____/____ (MM/DD/YYYY) Date 2: ____/____/____ (MM/DD/YYYY)
 - Health department Date 1: ____/____/____ (MM/DD/YYYY) Date 2: ____/____/____ (MM/DD/YYYY)
 - Urgent care Date 1: ____/____/____ (MM/DD/YYYY) Date 2: ____/____/____ (MM/DD/YYYY)
 - Telephone triage line Date 1: ____/____/____ (MM/DD/YYYY) Date 2: ____/____/____ (MM/DD/YYYY)
 - Other _____ Date 1: ____/____/____ (MM/DD/YYYY) Date 2: ____/____/____ (MM/DD/YYYY)
 - Unknown
- 39. Was the patient hospitalized? Yes No Unknown **If YES, please fill out hospitalization section below If no, skip to Question #53**
Purpose: Clinical indication No clinical indication (e.g., isolation for public health)

Hospitalization

- 40. Hospital name: _____ Hospital phone: _____
- 41. If yes, Admission date 1 ____/____/____ (MM/DD/YYYY), discharge date 1 ____/____/____ (MM/DD/YYYY) Patient still hospitalized
- 42. To where was the patient discharged?
 Home Transferred to another hospital Nursing facility/rehab Hospice Other _____ Unknown
- 43. If hospitalized more than once, please enter the second hospitalization's admission and discharge dates:
Hospital name: _____ Hospital phone: _____
Admission date 2 ____/____/____ (MM/DD/YYYY) Discharge date 2 ____/____/____ (MM/DD/YYYY)
 Patient still hospitalized
- 44. To where was the patient discharged?
 Home Transferred to another hospital Nursing facility/rehab Hospice Other _____ Unknown
- 45. First recorded vital signs: Temp _____ (Unit: °F / °C) Blood pressure: _____ (systolic) / _____ (diastolic)
Heart rate: _____ Resp rate: _____
O2 Sat: _____ (Type of support required when O2 saturation was measured: _____)



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Room Air
 Nasal Cannula
 Face Mask
 CPAP or BIPAP
 High Flow Nasal Cannula
 Invasive mechanical ventilation
 Other, specify: Unknown
 Fraction of Inspired Oxygen/Flow _____ %
 Liters/minute (LPM)
 Unknown
 NA

46. First recorded laboratory values for:

	Date (MM/DD/YYYY)	Value	Unit
White blood cell (WBC) count			<input type="checkbox"/> Cells x 10 ⁹ /L <input type="checkbox"/> x 1 000/ μ L <input type="checkbox"/> Other: _____
Absolute neutrophil count			<input type="checkbox"/> Cells x 10 ⁹ /L <input type="checkbox"/> x 1 000/ μ L <input type="checkbox"/> Other: _____
Absolute lymphocyte count			<input type="checkbox"/> Cells x 10 ⁹ /L <input type="checkbox"/> x 1 000/ μ L <input type="checkbox"/> Other: _____
Platelets (Plt)			<input type="checkbox"/> Cells x 10 ⁹ /L <input type="checkbox"/> x 1 000/ μ L <input type="checkbox"/> Other: _____
Aspartate transaminase (AST)			<input type="checkbox"/> U/L <input type="checkbox"/> IU/L <input type="checkbox"/> Other: _____
Alanine aminotransferase (ALT)			<input type="checkbox"/> U/L <input type="checkbox"/> IU/L <input type="checkbox"/> Other: _____
Lactate dehydrogenase (LDH)			<input type="checkbox"/> U/L <input type="checkbox"/> IU/L <input type="checkbox"/> Other: _____

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

ICU admission date 1 ____/____/____ (MM/DD/YYYY)

ICU discharge date 1 ____/____/____ (MM/DD/YYYY)

ICU admission date 2 ____/____/____ (MM/DD/YYYY)

ICU discharge date 2 ____/____/____ (MM/DD/YYYY)

48. During hospitalization, did the patient receive...

		Start Date (MM/DD/YYYY)	Last Date (MM/DD/YYYY)	Total Days
Supplemental Oxygen?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk			
BiPaP or CPAP use?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk			
High flow nasal cannula?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk			
Invasive mechanical ventilation?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk			
ECMO?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk			

49. Did the patient receive a discharge diagnosis of pneumonia (refer to clinical discharge summary)?

Yes No Unknown

50. Did the patient receive a discharge diagnosis of acute respiratory distress syndrome (ARDS) (refer to clinical discharge summary)?

Yes No Unknown

51. Clinical Discharge Diagnoses and ICD10 Discharge Codes

Clinical Discharge Diagnoses	ICD-10-CM Code
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

52. Did the patient receive any antiviral medications during hospitalization for this illness:

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Medication		Dose	Frequency	Start Date (MM/DD/YYYY)	Last Date (MM/DD/YYYY)	Total Days
Remdesivir	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM					
Other: _____	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM					
Other: _____	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM					

Imaging

53. Was a chest x-ray taken? Yes No Unknown
 54. Were any of these chest x-rays abnormal? Yes No Unknown
 Date of first abnormal chest x-ray: ____/____/____ (MM/DD/YYYY)

55. For first abnormal chest x-ray, please check all that apply: Report not available:

Air space density	<input type="checkbox"/>	Cannot rule out pneumonia	<input type="checkbox"/>	ARDS (acute respiratory distress syndrome)	<input type="checkbox"/>	Other	<input type="checkbox"/>
Air space opacity	<input type="checkbox"/>	Consolidation	<input type="checkbox"/>	Lung infiltrate	<input type="checkbox"/>	Pleural Effusion	<input type="checkbox"/>
Bronchopneumonia/pneumonia	<input type="checkbox"/>	Cavitation	<input type="checkbox"/>	Interstitial infiltrate	<input type="checkbox"/>	Empyema	<input type="checkbox"/>

56. Was a chest CT/MRI taken? Yes No Unknown
 57. Were any of these chest CT/MRIs abnormal? Yes No Unknown
 Date of first abnormal CT/MRI: ____/____/____ (MM/DD/YYYY)

58. For first abnormal chest CT/MRI, please check all that apply: Report not available:

Air space density	<input type="checkbox"/>	ARDS (acute respiratory distress syndrome)	<input type="checkbox"/>	Empyema	<input type="checkbox"/>	Enlarge epiglottis	<input type="checkbox"/>
Air space opacity/opacification	<input type="checkbox"/>	Lung infiltrate	<input type="checkbox"/>	Pneumothorax	<input type="checkbox"/>	Tracheal narrowing	<input type="checkbox"/>
Bronchopneumonia/pneumonia	<input type="checkbox"/>	Interstitial infiltrate	<input type="checkbox"/>	Pneumomediastinum	<input type="checkbox"/>	Ground glass opacities	<input type="checkbox"/>
Consolidation	<input type="checkbox"/>	Lobar infiltrate	<input type="checkbox"/>	Widened mediastinum	<input type="checkbox"/>	Other	<input type="checkbox"/>
Cavitation	<input type="checkbox"/>	Pleural effusion	<input type="checkbox"/>				

Lab Results

59. SARS-CoV-2 Testing (Please report further test results in comments)

Date of sample collection (MM/DD/YYYY)	Sample Type	Result
	<input type="checkbox"/> NP <input type="checkbox"/> OP <input type="checkbox"/> Sputum <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive
	<input type="checkbox"/> NP <input type="checkbox"/> OP <input type="checkbox"/> Sputum <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive
	<input type="checkbox"/> NP <input type="checkbox"/> OP <input type="checkbox"/> Sputum <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive
	<input type="checkbox"/> NP <input type="checkbox"/> OP <input type="checkbox"/> Sputum <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive
	<input type="checkbox"/> NP <input type="checkbox"/> OP <input type="checkbox"/> Sputum <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive

Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).



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	specify: _____
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60. Was patient tested for other viral respiratory pathogens during their illness? Yes (report results below) No Unknown

	Positive	Negative	Not Tested/ Unknown	Collection Date (MM/DD/YYYY)	Specimen Type
Flu A/H1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Flu A/H3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Flu B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Flu (no type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Respiratory syncytial virus/RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Adenovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Parainfluenza virus 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Parainfluenza virus 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Parainfluenza virus 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Parainfluenza virus 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Respiratory syncytial virus/RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Human metapneumovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Rhinovirus/enterovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Human coronavirus 229E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Human coronavirus HKU1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Human coronavirus NL63	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Human coronavirus OC43	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	

61. Were any bacterial culture tests performed during their illness? Yes No Unknown

If yes, was there a positive culture for a bacterial pathogen? Yes No Unknown

If yes, specify pathogen: _____

If yes, specify date of culture (MM/DD/YYYY): _____

If yes, site where pathogen identified: Blood Sputum Bronchoalveolar lavage (BAL) Endotracheal aspirate Pleural fluid

Cerebrospinal fluid (CSF) Other, specify: _____

If more than one bacterial culture test was performed, please record in additional comments.

Outcome

62. Did the patient die as a result of this illness?

Yes, Date: ___/___/___ (MM/DD/YYYY) No Unknown

Where did the death occur: Home Hospital ER Hospice Other, specify _____

Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).



CDC 2019-nCoV ID:

Form Approved: OMB: 0920-XXXX Exp. XX/XX/XXXX

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(If the following information is not currently available, please send an update later using death certificate or death note in hospital record.)

Contribution of COVID-19 to death Underlying/primary Contributing/secondary No contribution to death Unknown

Was autopsy performed? Yes No Unknown

Primary Cause of death (death certificate/coroner) _____

Any additional comments or notes?

This is the end of the case investigation form. Thank you very much for your time. If you have any questions please feel free to contact the CDC at 770-488-7100 or eocevent330@cdc.gov