State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Source Case state/local ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

State/local health dept.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Source Case CDC 2019-nCoV ID b: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact ID a: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact 2019-nCoV IDc: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case 0023CA has contacts 0023CA-001 and 0023CA-002
2. Complete with ID of the associated confirmed case who identified this contact
3. To be assigned at CDC

**Interviewer instructions: prior to interview with contact, please note the following information about the confirmed 2019-nCoV case that identified this contact***:*

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

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **……………PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……………………**Case Identification number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
|  |

## Demographic information

1. Date of birth (MM/DD/YYYY): / /
2. Age: \_\_\_\_\_\_\_ [ ]  years [ ]  months
3. Current residence: Country: \_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_County\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Ethnicity: [ ]  Hispanic or Latino [ ]  Not Hispanic or Latino
5. Race: [ ] White [ ] Asian [ ] American Indian/Alaska Native [ ] Black or African American [ ] Native Hawaiian/Other Pacific Islander
6. Sex: [ ]  Male [ ] Female

## Symptoms

1. In the past day, have you experienced any of the following symptoms?

| **Symptom** | **Symptom Present?** | **Duration (no. of days)**  |
| --- | --- | --- |
| **Systemic** |  |  |
| Fever >100.4F (38C) | [ ] Yes [ ] No [ ] Unk |  |
| Subjective fever (felt feverish) | [ ] Yes [ ] No [ ] Unk |  |
| Cough (new onset or worsening of chronic cough) | [ ] Yes [ ] No [ ] Unk |  |
| Shortness of breath (dyspnea) | [ ] Yes [ ] No [ ] Unk |  |
| Vomiting | [ ] Yes [ ] No [ ] Unk |  |
| Nausea | [ ] Yes [ ] No [ ] Unk |  |
| Diarrhea (≥3 loose/looser than normal stools/24hr period) | [ ] Yes [ ] No [ ] Unk |  |

## Medical History

1. Do you have any of the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Chronic Lung Disease | [ ] Yes | [ ] No | [ ] Unknown |  Specify: |
| Smoking | [ ] Yes, current | [ ] Yes, former |  [ ] No | [ ] Unknown |
| Active tuberculosis | [ ] Yes | [ ] No | [ ] Unknown |  |
| Diabetes Mellitus  | [ ] Yes | [ ] No | [ ] Unknown | Specify: |
| Cardiovascular disease | [ ] Yes | [ ] No | [ ] Unknown | Specify: |
| Renal disease | [ ] Yes | [ ] No | [ ] Unknown | Specify: |
| Liver disease | [ ] Yes | [ ] No | [ ] Unknown | Specify: |
| Immunocompromised Condition | [ ] Yes | [ ] No | [ ] Unknown | Specify: |
| Neurologic/neurodevelopmental disorder | [ ] Yes | [ ] No | [ ] Unknown | Specify: |
| Other chronic diseases | [ ] Yes | [ ] No | [ ] Unknown | Specify: |

## Social History

1. Have you been to a shelter in the last 2 weeks (14 days) before your symptoms started or your test was positive? (Any of the symptoms listed above)

If yes, name of shelters where you have slept? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not in shelters, where have you slept? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Where have you eaten your meals in the last 2 weeks (14 days) before your symptoms started or your test was positive?

Names of places you went to get your meals \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been to any places in the last 2 weeks (14 days) to hang out or be with other people?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did you receive any other services in the last 2 weeks (14 days) before your symptoms or your test was positive started? (Examples: Day shelters, shower/bathroom/lockers, case management, job placement/training)

Names of places\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did you receive any medical services in the last 2 weeks (14 days) before your symptoms started or your test was positive? (Examples: mobile clinic, hospitals, ER, clinic)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did you have a court date or stay in a correctional facility in the 2 weeks (14 days) before your symptoms started or your test was positive?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Laboratory testing

27. If yes, what type of specimen was collected?

|  |  |
| --- | --- |
| **Specimen Type** | **ORIGINAL Specimen ID** |
| [ ]  NP swab  |  |
| [ ]  OP swab  |  |
| [ ]  Nasal swab  |  |

**This is the end of the case report 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** **eocreport@cdc.gov**