Reporting jurisdiction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case state/local ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reporting health department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ CDC 2019-nCoV ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact ID a: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ NNDSS loc. rec. ID/Case ID b: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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. bFor 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

1. Report date to CDC (MM/DD/YYYY): \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_
2. 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Date of birth (month and year): Month \_\_\_\_ Year \_\_\_\_\_
2. Age: \_\_\_\_\_\_\_\_\_\_\_\_ Age units: Years Months Days
3. Sex: Male Female
4. Ethnicity:  Hispanic/Latino  Non-Hispanic/Latino  Not specified
5. Race (check all that apply):  White  Asian  American Indian/Alaska Native  Black  
    Native Hawaiian/Other Pacific Islander  Unknown  Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. County of Residence:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State of Residence:\_\_\_\_\_\_\_\_
7. Country of Residence:  United States  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If student, what grade level? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If child, does s/he attend day care?  Yes  No  Unknown

## Travel history

1. In the 14 days prior to illness onset, were you traveling away from your home internationally?

Yes  No  Unknown

1. In the 14 days prior to illness onset, were you traveling away from your home within the United States?

Yes  No  Unknown

1. 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 |  |  |  |  |
| Trip 3 |  |  |  |  |
| Trip 4 |  |  |  |  |
| Trip 5 |  |  |  |  |

## Exposure history

1. 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) \_\_\_\_\_\_\_\_\_\_\_\_

1. 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):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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.)? | Yes  No  Unknown |  |
| …have close contact (e.g. caring for, speaking with, or touching) with any ill persons? | Yes  No  Unknown |  |
| …attend a mass gathering (e.g., religious event, wedding, party, dance, concert, banquet, festival, sports event, or other event)? | Yes  No  Unknown |  |
| …use public transportation (bus, train, airplane)? | Yes  No  Unknown |  |
| …attend or work at a school or daycare? | Yes  No  Unknown |  |
| …have a household member who attended school or daycare? | Yes  No  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)? | Yes  No  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? | Yes  No  Unknown  If yes where did the person travel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

1. 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: | Y  N  Unk  If yes, what was your role:  Physician  Nurse  Administration staff  Housekeeping  Patient transport  Other, specify\_\_\_\_\_\_\_\_\_\_ | Hospital  Urgent Care  Doctor’s office/clinic | | Dialysis unit/center  Long Term Care Facility  Other (specify) |  |
| Volunteer in healthcare setting | Y  N  Unk | Hospital  Urgent Care  Doctor’s office/clinic | | Dialysis unit/center  Long Term Care Facility  Other (specify) |  |
| Have direct patient contact | Y  N  Unk | Hospital  Urgent Care  Doctor’s office/clinic | | Dialysis unit/center  Long Term Care Facility  Other (specify) |  |
| Visit healthcare setting as a patient (not just for this illness) | Y  N  Unk | Hospital  Urgent Care  Doctor’s office/clinic | | Dialysis unit/center  Long Term Care Facility  Other (specify) |  |
| Visit healthcare setting for any reason other than as a patient | Y  N  Unk | Hospital  Urgent Care  Doctor’s office/clinic | | Dialysis unit/center  Long Term Care Facility  Other (specify) |  |
| Contact with a known COVID-19 case-patient in a healthcare setting | Y  N  Unk  If yes, as a  Patient  Visitor  HCW | Hospital  Urgent Care  Doctor’s office/clinic | Dialysis unit/center  Long Term Care Facility  Other (specify) | |  |

1. 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

1. 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) |
| --- | --- | --- | --- | --- | --- |
| A  B  C |  |  |  | Y  N  Unk |  |
| A  B  C |  |  |  | Y  N  Unk |  |
| A  B  C |  |  |  | Y  N  Unk |  |
| A  B  C |  |  |  | Y  N  Unk |  |
| A  B  C |  |  |  | Y  N  Unk |  |
| A  B  C |  |  |  | Y  N  Unk |  |
| A  B  C |  |  |  | Y  N  Unk |  |

## Symptoms

1. If symptomatic, onset date of first symptom (MM/DD/YYYY): \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ Unknown Asymptomatic
2. If experienced symptoms, are you Still symptomaticUnknown symptom status Symptoms resolved

If symptoms resolved, date of symptom resolution (MM/DD/YYYY): \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Unknown date

1. During this illness, did you experience any of the following symptoms?

| **Symptom** |  | **Symptom** |  |
| --- | --- | --- | --- |
| Fever ≥100.4F (38C) | Yes No Unk | Cough (new onset or worsening of chronic cough) | Yes No Unk |
| Highest temp\_\_\_\_\_\_\_\_ °F |  | Dry | Yes No Unk |
| Date of onset (MM/DD/YYYY) \_\_\_/\_\_\_/\_\_\_\_\_\_\_ |  | Productive | Yes No Unk |
| Duration of fever ≥100.4F (38C) (days) \_\_\_\_\_\_\_\_\_\_\_\_ |  | Bloody sputum (hemoptysis) | Yes No Unk |
| Subjective fever (felt feverish) | Yes No Unk | Shortness of breath (dyspnea) | Yes No Unk |
| Chills | Yes No Unk | Wheezing | Yes No Unk |
| Fatigue | Yes No Unk | Chest Pain | Yes No Unk |
| Muscle aches (myalgia) | Yes No Unk | Abdominal pain | Yes No Unk |
| Rash | Yes No Unk | Vomiting | Yes No Unk |
| Headache | Yes No Unk | Nausea | Yes No Unk |
| Eye redness (conjunctivitis) | Yes No Unk | Diarrhea (≥3 loose/looser than normal stools/24hr period) | Yes No Unk |
| Runny nose (rhinorrhea) | Yes No Unk | Poor Feeding/Poor appetite | Yes No Unk |
| Sore throat | Yes No Unk | Seizures | Yes No Unk |
| Other, specify: | Yes No Unk | Other, specify: | Yes No Unk |

## Past medical history

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

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

1. Current height: \_\_\_\_\_\_\_\_\_ (inches) OR \_\_\_\_\_\_\_\_\_\_ (cm)
2. Current weight: \_\_\_\_\_\_\_\_\_ (pounds) OR \_\_\_\_\_\_\_\_\_\_ (kg)
3. If female, are you currently pregnant?  Yes Weeks pregnant at illness onset\_\_\_\_\_\_\_\_\_  No  Unknown
4. If female, are you postpartum (6 weeks postpartum)?  Yes  No  Unknown
5. If female, are you breastfeeding?  Yes  No  Unknown
6. If child, is he/she being breastfed?  Yes  No  Unknown

## Social history

1. Do you currently smoke cigarettes?  Yes  No  Unknown   
   If yes, how many packs of cigarettes per day? \_\_\_\_\_\_ For how many years? \_\_\_\_\_
2. 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)
3. Do you currently use e-cigarettes/vape-pen?  Yes  No  Unknown
4. 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

1. 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)

1. Did you miss work or school for this illness?  Yes  No  Unknown

If yes, how many days during illness? \_\_\_\_\_\_\_\_\_\_

1. Did you receive any medical care for the illness?  Yes  No  Unknown
2. 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

1. 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

1. Hospital name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. If yes, Admission date 1 \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY) , discharge date 1 \_\_\_/\_\_\_/\_\_\_\_ (MM/DD/YYYY)  Patient still hospitalized
3. To where was the patient discharged?

Home  Transferred to another hospital  Nursing facility/rehab  Hospice  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unknown

1. 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

1. To where was the patient discharged?

Home  Transferred to another hospital  Nursing facility/rehab  Hospice  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unknown

1. First recorded vital signs: Temp\_\_\_\_\_\_\_\_\_ (Unit:  °F /  oC) Blood pressure: \_\_\_\_\_\_\_\_ (systolic) / \_\_\_\_\_\_\_\_ (diastolic)

Heart rate: \_\_\_\_\_\_\_\_\_ Resp rate:\_\_\_\_\_\_\_\_\_\_\_

O2 Sat: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Type of support required when O2 saturation was measured:

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

1. First recorded laboratory values for:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Date  (MM/DD/YYYY) | Value | Unit |
| White blood cell (WBC) count |  |  | Cells x 109/L  x 1 000/μL  Other: \_\_\_\_\_\_ |
| Absolute neutrophil count |  |  | Cells x 109/L  x 1 000/μL  Other: \_\_\_\_\_\_ |
| Absolute lymphocyte count |  |  | Cells x 109/L  x 1 000/μL  Other: \_\_\_\_\_\_ |
| Platelets (Plt) |  |  | Cells x 109/L  x 1 000/μL  Other: \_\_\_\_\_\_ |
| Aspartate transaminase (AST) |  |  | U/L  IU/L  Other: \_\_\_\_\_\_ |
| Alanine aminotransferase (ALT) |  |  | U/L  IU/L  Other: \_\_\_\_\_\_ |
| Lactate dehydrogenase (LDH) |  |  | U/L  IU/L  Other: \_\_\_\_\_\_ |

1. 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)

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Start Date (MM/DD/YYYY) | Last Date (MM/DD/YYYY) | Total Days |
| Supplemental Oxygen? | Y  N  Unk |  |  |  |
| BiPaP or CPAP use? | Y  N  Unk |  |  |  |
| High flow nasal cannula? | Y  N  Unk |  |  |  |
| Invasive mechanical ventilation? | Y  N  Unk |  |  |  |
| ECMO? | Y  N  Unk |  |  |  |

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

Yes  No  Unknown

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

Yes  No  Unknown

1. Clinical Discharge Diagnoses and ICD10 Discharge Codes

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

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Medication |  | Dose | Frequency | Start Date (MM/DD/YYYY) | Last Date (MM/DD/YYYY) | Total Days |
| Remdesivir | PO  IV  IM |  |  |  |  |  |
| Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | PO  IV  IM |  |  |  |  |  |
| Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | PO  IV  IM |  |  |  |  |  |

## Imaging

1. Was a chest x-ray taken?  Yes  No  Unknown
2. Were any of these chest x-rays abnormal?  Yes  No  Unknown

Date of first abnormal chest x-ray: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Air space density |  | Cannot rule out pneumonia |  | ARDS (acute respiratory distress syndrome) |  | Other |  |
| Air space opacity |  | Consolidation |  | Lung infiltrate |  | Pleural Effusion |  |
| Bronchopneumonia/pneumonia |  | Cavitation |  | Interstitial infiltrate |  | Empyema |  |

1. Was a chest CT/MRI taken?  Yes  No  Unknown
2. Were any of these chest CT/MRIs abnormal?  Yes  No  Unknown

Date of first abnormal CT/MRI: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY)

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Air space density |  | ARDS (acute respiratory distress syndrome) |  | Empyema |  | Englarge epiglottis |  |
| Air space opacity/opacification |  | Lung infiltrate |  | Pneumothorax |  | Tracheal narrowing |  |
| Bronchopneumonia/pneumonia |  | Interstitial infiltrate |  | Pneumomediastinum |  | Ground glass opacities |  |
| Consolidation |  | Lobar infiltrate |  | Widened mediastinum |  | Other |  |
| Cavitation |  | Pleural effusion |  |  |  |  |  |

## Lab Results

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

|  |  |  |
| --- | --- | --- |
| Date of sample collection (MM/DD/YYYY) | Sample Type | Result |
|  | NP  OP  Sputum  Other, specify:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Pos  Neg  Inconclusive |
|  | NP  OP  Sputum  Other, specify:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Pos  Neg  Inconclusive |
|  | NP  OP  Sputum  Other, specify:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Pos  Neg  Inconclusive |
|  | NP  OP  Sputum  Other, specify:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Pos  Neg  Inconclusive |
|  | NP  OP  Sputum  Other, specify:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Pos  Neg  Inconclusive |

1. 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/YYY) | Specimen Type |
| Flu A/H1 |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Flu A/H3 |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Flu B |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Flu (no type) |  |  |  |  |  |
| Respiratory syncytial virus/RSV |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Adenovirus |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Parainfluenza virus 1 |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Parainfluenza virus 2 |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Parainfluenza virus 3 |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Parainfluenza virus 4 |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Respiratory syncytial virus/RSV |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Human metapneumovirus |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Rhinovirus/enterovirus |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Human coronavirus 229E |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Human coronavirus HKU1 |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Human coronavirus NL63 |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Human coronavirus OC43 |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |
| Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |  |

1. 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

1. 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(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**