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. 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:_____
3. Date of birth (month and year): Month ____ Year _____
4. Age: _____ Age units: ☐ Years ☐ Months ☐ Days
5. Sex: ☐ Male ☐ Female
6. Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Not specified
7. Race (check all that apply): ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Black
   ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ Other, specify: _____
8. County of Residence:_____ State of Residence:_____
9. Country of Residence: ☐ United States ☐ Other, specify_____
10. Occupation:_____
    If student, what grade level? _____
    If child, does s/he attend day care? ☐ Yes ☐ No ☐ Unknown

Travel history

11. In the 14 days prior to illness onset, were you traveling away from your home internationally?
    ☐ Yes ☐ No ☐ Unknown
12. In the 14 days prior to illness onset, were you traveling away from your home within the United States?
    ☐ Yes ☐ No ☐ Unknown
13. 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				

COVID-19 Case Investigation Form

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.)?	☐ 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:_____	

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:	☐ Y ☐ N ☐ Unk If yes, what was your role: ☐ Physician ☐ Nurse ☐ Administration	☐ Hospital ☐ Urgent Care ☐ Doctor's office/clinic	☐ Dialysis unit/center ☐ Long Term Care Facility ☐ Other (specify)	

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-XXXX Exp. XX/XX/XXXX

COVID-19 Case Investigation Form

	staff ☐ Housekeeping ☐ Patient transport ☐ 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)	

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)
☐ A ☐ B ☐ C				☐ Y ☐ N ☐ Unk	
☐ A ☐ B ☐ C				☐ Y ☐ N ☐ Unk	
☐ A ☐ B ☐ C				☐ Y ☐ N ☐ Unk	

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-XXXX Exp. XX/XX/XXXX

COVID-19 Case Investigation Form

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	

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 ≥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

24. 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	

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-XXXX Exp. XX/XX/XXXX

COVID-19 Case Investigation Form

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: _____

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

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-XXXX Exp. XX/XX/XXXX

COVID-19 Case Investigation Form

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:

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-XXXX Exp. XX/XX/XXXX

COVID-19 Case Investigation Form

☐ 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			☐ 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:_____

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?	☐ 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			

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:

COVID-19 Case Investigation Form

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

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

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	☐	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

59. 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,	☐ Pos ☐ Neg ☐ Inconclusive

COVID-19 Case Investigation Form

	specify: _____	

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/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: _____	☐	☐	☐	____/____/_____	

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_____

CDC 2019-nCoV ID: [ ]

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

COVID-19 Case Investigation Form

(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