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 Info

Name of Interviewer: Phone: Email:

Affiliation/Organization:

What is the current status of this person?

Lab-confirmed case Probable case

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:

EpiX notification of travelers. If yes, DGMQID:

Unknown

Report date of case to CDC (MM/DD/YYYY):

Date first positive specimen (MM/DD/YYYY):

Unknown N/A

Hospitalization, ICU, and Death Information

Was the patient hospitalized?

Yes No Unknown

If yes, Admission date:

Discharge date :

If hospitalized, was a translator required?

Yes No Unknown

If yes, specify **language**:

Was the patient admitted to an intensive care unit (ICU)?

Yes No Unknown

If yes, ICU admission date:

ICU Discharge date:

Did the patient die as a result of this illness?

Yes No Unknown

If yes, date of death (MM/DD/YYYY): Date of death unknown date

Case Demographics

Date of Birth:

Age: Age units (yr/mo/day):

Residence State: County :

Does this case have any tribal affiliation? yes

Enrolled member? Yes

Tribe name(s):

Sex:

Male Other

Female Unknown

If female, currently **pregnant?**

Yes No Unknown

Ethnicity:

Hispanic/Latino

Non-Hispanic/Latino

Unknown

Race (check all that apply):

Black White Asian

American Indian/Alaska Native

Native Hawaiian/Other Pacific Islander

Unknown Other:

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

Yes 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

Long-term care facility Nursing home/assisted living facility

Unknown Other:

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 normal residence). Specify:

International travel. Specify country(s):

Cruise ship /vessel travel passenger or crew, Name of ship:

Workplace: Is the workplace **critical** infrastructure

(e.g., healthcare , grocery store)? Yes No Unknown

Specify workplace setting:

Airport/airplane

Adult congregate living facility (nursing, assisted living, or long-term care facility)

School/university/childcare center

Correctional facility

Community event/mass gathering

Animal with confirmed or suspected COVID-19. Specify :

Unknown exposures in the 14 days prior to illness onset

Other exposure, Specify

Contact with 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 (patient, visitor, healthcare worker)

Was this person a U.S. case?

If Yes, nCoV

No, International case/contact occurred abroad

Unknown if U.S. or international

case Is this case part of an outbreak?

Yes, specify outbreak name: ☐ No ☐ Unknown

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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**? (MM/DD/YYYY):
Unknown symptom onset date

Did the patient's symptoms resolve?
Date symptom resolution (MM/DD/YYYY):
No, still symptomatic
Symptoms resolved, unknown date
Unknown if symptoms resolved

Did the patient develop **pneumonia**? Yes No Unk

Did the patient have **acute respiratory distress syndrome**?
Yes No Unk

Did the patient have an **abnormal EKG**?
Yes No Unk N/A, no EKG done

Did the patient have an **abnormal chest X-ray**?
Yes No Unk N/A, no chest X-ray done

Did the patient receive mechanical ventilation **(MV)/intubation**?
Yes No Unk If yes, total days MV (days) :

Did the patient have **another diagnosis/etiology** for their illness?
Yes No Unk

Did the patient receive **ECMO**?
Yes No Unk

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

	Y	N	Unknown
Fever			
Subjective fever (felt feverish)			
Chills			
Rigors			
Muscle aches (myalgia)			
Runny Nose (rhinorrhea)			
Sore throat			
New olfactory and taste disorder(s)			
Headache			
Fatigue			

	Y	N	Unknown
Cough (new onset or worsening of chronic cough)			
Wheezing			
Shortness of Breath (dyspena)			
Chest Pain			
Nausea or vomiting			
Abdominal Pain			
Diarrhea (>3 loose stools /24hr period)			
Other, Specifiy			

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

	Y	N	Unk
Diabetes Mellitus			
Hypertension			
Severe obesity (BMI > 40)			
Cardiovascular disease			
Chronic Renal disease			
Chronic Liver disease			
Chronic Lung Disease (asthma, emphysema, COPD)			
Other Chronic, specify:			
Other underlying conditons/risk behavior, specify:			

	Y	N	Unk
Immunosuppressive condition			
Autoimmune condition			
Current Smoker			
Former Smoker			
Substance abuse or misuse			
Disability (neurologic, neuro developmental, intellectual, physical, vision or hearing impairment) Specify:			
Psychological/psychiatric condtion, Specify:			

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