

CDC 2019-nCoV ID:

Form Approved: OMB: 0920-1011 Exp. 4/23/2020

.....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 Person Under Investigation (PUI) and 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. ^bFor NNDSS reporters, use GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Last _____ First _____

Affiliation/Organization: _____ Telephone _____ Email _____

Basic information

What is the current status of this person? <input type="checkbox"/> Patient under investigation (PUI) <input type="checkbox"/> Laboratory-confirmed case Report date of PUI to CDC (MM/DD/YYYY): _____ Report date of case to CDC (MM/DD/YYYY): _____ County of residence: _____ State of residence: _____		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Not specified Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other		Date of first positive specimen collection (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A Did the patient develop pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No Did the patient have acute respiratory distress syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No Did the patient have another diagnosis/etiology for their illness? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No Did the patient have an abnormal chest X-ray? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No		Was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, admission date 1 ____/____/____ (MM/DD/YYYY) If yes, discharge date 1 ____/____/____ (MM/DD/YYYY) Was the patient admitted to an intensive care unit (ICU)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the patient receive mechanical ventilation (MV)/intubation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, total days with MV (days) _____ Did the patient receive ECMO? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the patient die as a result of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of death (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Unknown date of death																
Race (check all that apply): <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____		Date of birth (MM/DD/YYYY): ____/____/____ Age: _____ Age units(yr/mo/day): _____																				
Symptoms present during course of illness: <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Unknown		If symptomatic, onset date (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Unknown		If symptomatic, date of symptom resolution (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Still symptomatic <input type="checkbox"/> Unknown symptom status <input type="checkbox"/> Symptoms resolved, unknown date																		
Is the patient a health care worker in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Does the patient have a history of being in a healthcare facility (as a patient, worker or visitor) in China? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply): <table border="0"> <tr> <td><input type="checkbox"/> Travel to Wuhan</td> <td><input type="checkbox"/> Community contact with another lab-confirmed COVID-19 case-patient</td> <td><input type="checkbox"/> Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology</td> </tr> <tr> <td><input type="checkbox"/> Travel to Hubei</td> <td><input type="checkbox"/> Any healthcare contact with another lab-confirmed COVID-19 case-patient</td> <td><input type="checkbox"/> Other, specify: _____</td> </tr> <tr> <td><input type="checkbox"/> Travel to mainland China</td> <td><input type="checkbox"/> Patient <input type="checkbox"/> Visitor <input type="checkbox"/> HCW</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Travel to other non-US country specify: _____</td> <td><input type="checkbox"/> Animal exposure</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Household contact with another lab-confirmed COVID-19 case-patient</td> <td></td> <td></td> </tr> </table> If the patient had contact with another COVID-19 case, was this person a U.S. case? <input type="checkbox"/> Yes, nCoV ID of source case: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A								<input type="checkbox"/> Travel to Wuhan	<input type="checkbox"/> Community contact with another lab-confirmed COVID-19 case-patient	<input type="checkbox"/> Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology	<input type="checkbox"/> Travel to Hubei	<input type="checkbox"/> Any healthcare contact with another lab-confirmed COVID-19 case-patient	<input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Travel to mainland China	<input type="checkbox"/> Patient <input type="checkbox"/> Visitor <input type="checkbox"/> HCW	<input type="checkbox"/> Unknown	<input type="checkbox"/> Travel to other non-US country specify: _____	<input type="checkbox"/> Animal exposure		<input type="checkbox"/> Household contact with another lab-confirmed COVID-19 case-patient		
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Under what process was the PUI or case first identified? (check all that apply): <input type="checkbox"/> Clinical evaluation leading to PUI determination <input type="checkbox"/> Contact tracing of case patient <input type="checkbox"/> Routine surveillance <input type="checkbox"/> EpiX notification of travelers; if checked, DGMQID _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____																						

Public reporting burden of this collection of information is estimated to average 30 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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Symptoms, clinical course, past medical history and social history

Collected from (check all that apply): ☐ Patient interview ☐ Medical record review

During this illness, did the patient experience any of the following symptoms?	Symptom Present?
Fever >100.4F (38C) ^c	<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
Chills	<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
Runny nose (rhinorrhea)	<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
Cough (new onset or worsening of chronic cough)	<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
Nausea or 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
Abdominal pain	<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
Other, specify: _____	

Pre-existing medical conditions?

☐ Yes ☐ No ☐ Unknown

Chronic Lung Disease (asthma/emphysema/COPD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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	
Chronic Renal disease	<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	
Immunocompromised Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Neurologic/neurodevelopmental	<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) _____
If female, currently pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Current smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Former smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Respiratory Diagnostic Testing

Test	Pos	Neg	Pend.	Not done
Influenza rapid Ag <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza PCR <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. metapneumovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parainfluenza (1-4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adenovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rhinovirus/enterovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronavirus (OC43, 229E, HKU1, NL63)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. pneumoniae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. pneumoniae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specimens for COVID-19 Testing

Specimen Type	Specimen ID	Date Collected	Sent to CDC	State Lab Tested
NP Swab			<input type="checkbox"/>	<input type="checkbox"/>
OP Swab			<input type="checkbox"/>	<input type="checkbox"/>
Sputum			<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify: _____			<input type="checkbox"/>	<input type="checkbox"/>

Additional State/local Specimen IDs: _____

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