COVID-19 Case Report Form

For use in Correctional settings only

INTERVIEWER INFORMATION

Interviewer Last Name: _____ **First:** _____

Phone Number: _____ **Email:** _____

Jail Name: _____ **Job Title:** _____

CASE DEMOGRAPHICS

Last Name: _____ **First:** _____ **Middle:** _____

Date of Birth: _____/_____/_____ **Reported Age:** _____ **Sex:** ☐ Male ☐ Female ☐ Other ☐ Unknown

Phone Number: _____ **If female, currently pregnant?:** ☐ Yes ☐ No ☐ Unknown

Residential Street Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

Race: ☐ American Indian / Alaskan ☐ Asian ☐ Black / African American ☐ Hawaiian / Pacific Islander ☐ White ☐ Unknown ☐ Other: _____

Date of Entry to the Jail: _____/_____/_____ **Inmate Number:** _____

HOSPITALIZATION AND DEATH INFORMATION

Was the patient hospitalized: ☐ Yes ☐ No ☐ Unknown **Admission Date:** ____/____/_____ **Discharge Date:** ____/_____/_____

Did the patient die as a result of this illness? ☐ Yes ☐ No ☐ Unknown

If yes, **Date of Death:** _____/_____/_____ **or** ☐ Unknown date of death

CASE CLASSIFICATION AND IDENTIFICATION

Did the patient have a positive PCR test for COVID-19 (not an antibody test)?: ☐ Yes ☐ No ☐ Unknown

HEALTHCARE WORKER INFORMATION

Is the patient a healthcare worker in the United States? ☐ Yes ☐ No ☐ Unknown

If yes, **what is their job setting?** ☐ Hospital ☐ Long-term care facility ☐ Rehabilitation facility ☐ Nursing home / assisted living facility ☐ Unknown ☐ Other, specify: _____

CLINICAL COURSE, SYMPTOMS, PAST MEDICAL HISTORY, AND SOCIAL HISTORY

Symptoms present during course of illness? ☐ Symptomatic ☐ Asymptomatic ☐ Unknown

If symptomatic, what was the onset date? _____/_____/_____ **or** ☐ Unknown symptom onset date

Did the patient's symptoms resolve? If yes, date of resolution: _____/_____/_____

☐ No, still symptomatic ☐ Symptoms resolved, unknown date ☐ Unknown if symptoms resolved

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

	Yes	No	Unk		Yes	No	Unk
Fever >100.4°F (38°C)	☐	☐	☐	**Cough (new onset or worsening of chronic cough)**	☐	☐	☐
Subjective fever (felt feverish)	☐	☐	☐	**Wheezing**	☐	☐	☐
Chills	☐	☐	☐	**Shortness of breath (dyspnea)**	☐	☐	☐
Rigors (shivering and rise in temperature)	☐	☐	☐	**Difficulty breathing**	☐	☐	☐
Muscle aches (myalgia)	☐	☐	☐	**Chest pain**	☐	☐	☐
Runny nose (rhinorrhea)	☐	☐	☐	**Nausea or vomiting**	☐	☐	☐
Sore throat	☐	☐	☐	**Abdominal pain**	☐	☐	☐
New olfactory and taste disorder(s)	☐	☐	☐	**Diarrhea (≥ 3 loose stools / 24 hr period)**	☐	☐	☐
Headache	☐	☐	☐	**Other, specify:** _____	☐	☐	☐
Fatigue	☐	☐	☐	_____			

EXPOSURE INFORMATION

In the 14 days prior to illness onset, did the patient has any exposure to a known COVID-19 case? ☐ Yes ☐ No ☐ Unknown

If yes, **what type of contact?**

☐ Household ☐ Community-associated ☐ Healthcare-associated (patient, visitor, or healthcare worker)

Is this case part of a known outbreak? ☐ Yes ☐ No ☐ Unknown

If yes, **specify outbreak name:** _____