Human Infection with 2019 Novel Coronavirus Case Report Form

Reporting Jurisdiction: [Blank]
Reporting Health Department: [Blank]
Contact ID*: [CDC 2019-nCoV ID]
NNDSS loc. rec. ID/Case IDb: [Blank]

Case Classification and Identification

What is the current status of this person? [Blank]
Was this case lost to follow up? [Blank]
If probable, select reason for case classification:
- Meets 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

Under what process was the case first identified? (check all that apply)
- Clinical evaluation
- Routine surveillance
- Contact tracing of case patient
- Other, specify:
- EpiX notification of travelers. If yes, DGMQID:
- Unknown
- Report date of case to CDC (MM/DD/YYYY):
- Date of first positive specimen collection (MM/DD/YYYY):
- Yes: N/A

Hospitalization, ICU, and Death Information

Was the patient hospitalized? [Yes No Unknown]
If yes, admission date 1 discharge date 1
- Yes: N/A

Was the patient admitted to an intensive care unit (ICU)? [Yes No Unknown]
If yes, admission date 1 discharge date 1
- Yes: N/A

Did the patient die as a result of this illness? [Yes No Unknown]
If yes, date of death (MM/DD/YYYY): N/A

Case Demographics

Date of birth (MM/DD/YYYY): [Blank]
Age: [Blank] Age units (yr/mo/day):
Sex: [Blank]
Ethnicity: [Blank]
Race (check all that apply):
- Black
- White
- Asian
- American Indian/Alaska Native
- Native Hawaiian/Other Pacific Islander
- Unknown

State of residence: [Blank] County of residence: [Blank]
Does this case have any tribal affiliation? [Yes No Unknown]
If yes, enrolled member? [Yes No Unknown]
Tribe name(s): [Blank]

Which would best describe where the patient was staying at the time of illness onset?
- House/single family home
- Apartment
- Homeless shelter
- Hotel/motel
- Nursing home/assisted living facility
- Long-term care facility
- Other, specify:
- Rehabilitation facility
- Acute care inpatient facility
- Correctional facility
- Other (specify):
- Group home
- Unknown

Healthcare Worker Information

Is the patient a health care worker in the United States? [Yes No Unknown]
If yes, what is their occupation (type of job)? [Blank]
If yes, is their workplace critical infrastructure (e.g., healthcare setting, grocery store)?
- Yes
- No

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 of normal residence). Specify state(s):
- International travel. Specify country(s):
- Cruise ship or vessel travel as passenger or crew member. Specify name of ship:
- Workplace
- If yes, is the workplace critical infrastructure (e.g., healthcare setting, grocery store)?
- Yes
- No

- Airport/airplane
- Adult congregate living facility (nursing, assisted living, or long-term care facility)
- K-12 school
- College/university
- Childcare center
- Correctional facility
- Community event/mass gathering
- Animal with confirmed or suspected COVID-19. Specify animal:
- Contact with a 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 contact (patient, visitor, or healthcare worker)
- Was this person a U.S. case?
- Yes
- No

- Unknown if U.S. or international case
- Is this case part of an outbreak?
- Yes
- No

- Unknown
- Other exposures, specify:
- Unknown exposures in the 14 days prior to illness onset
### Human Infection with 2019 Novel Coronavirus Case Report Form

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

<table>
<thead>
<tr>
<th>Symptoms present during course of illness</th>
<th>If case was symptomatic:</th>
<th>Did the patient's symptoms resolve?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Symptomatic</td>
<td>What was the onset date?</td>
<td>Date of symptom resolution (MM/DD/YYYY): <strong>/</strong>/____</td>
</tr>
<tr>
<td>☐ Asymptomatic</td>
<td>Onset date (MM/DD/YYYY): <strong>/</strong>/____</td>
<td>No, still symptomatic</td>
</tr>
<tr>
<td>☐ Unknown</td>
<td>Unknown symptom onset date</td>
<td>Symptoms resolved, unknown date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unknown if symptoms resolved</td>
</tr>
</tbody>
</table>

**Did the patient develop pneumonia?**
- Yes
- No
- Unknown

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

**Did the patient have an abnormal chest X-ray?**
- Yes
- No
- Unknown

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

**Did the patient receive mechanical ventilation (MV)/intubation?**
- Yes
- No
- Unknown

**Was the disclosure authorized by the case or their guardian?**
- Yes, obtained written HIPAA Authorization Form
- HIPAA Exception, obtained verbal authorization
- HIPAA Exception, no authorization obtained (uncooperative case/guardian)

**Additional Comments or Notes**

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**SARS-CoV-2 Testing (approved by FDA or other designated authority)**

<table>
<thead>
<tr>
<th>Test</th>
<th>Pos</th>
<th>Neg</th>
<th>Indet./Inconc.</th>
<th>Pend.</th>
<th>Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Molecular amplification test (RT PCR)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Serologic test</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other (specify):</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
</tbody>
</table>

**Specimens for CoV-19 Testing**

<table>
<thead>
<tr>
<th>Specimen ID</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Vaccination**

- Did the patient ever receive COVID-19 vaccine?
  - Yes
  - No
  - Unknown

**Vaccine History Comments**

<table>
<thead>
<tr>
<th>Vaccination doses prior to onset:</th>
<th>Date of last dose prior to illness onset:</th>
</tr>
</thead>
<tbody>
<tr>
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<td><strong>/</strong>/____</td>
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