

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ____/____/____



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

^aOnly 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: _____ Telephone: _____ Email: _____
 Affiliation/Organization: _____

Case Classification and Identification

What is the current status of this person? **Was this case lost to follow up?**
 Lab-confirmed case* Probable case Yes No Unknown
 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, 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): ____/____/____ Unknown N/A

Hospitalization, ICU, and Death Information

Was the patient hospitalized? Yes No Unknown
 If yes, admission date 1 ____/____/____ (MM/DD/YYYY) discharge date 1 ____/____/____
 If hospitalized, was a translator required? Yes No Unknown
 If yes, specify which language: _____

Was the patient admitted to an intensive care unit (ICU)? Yes No Unknown
 If yes, admission date 1 ____/____/____ (MM/DD/YYYY) discharge date 1 ____/____/____

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

Case Demographics

Date of birth (MM/DD/YYYY): ____/____/____
 Age: _____ Age units (yr/mo/day): _____
State of residence: _____ **County of residence:** _____

Sex: Male Other Female Unknown
 If female, currently pregnant? Yes No Unknown

Ethnicity: Hispanic/Latino Unknown Non-Hispanic/Latino
Primary language: _____

Race (check all that apply): Black White Asian American Indian/Alaska Native Native Hawaiian/Other Pacific Islander Unknown Other, specify: _____

Does this case have any tribal affiliation? yes
 Tribe name(s): _____ Enrolled member? yes

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
 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 Other, specify: _____
 Long-term care facility Nursing home/assisted living facility Unknown

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, specify workplace setting: _____ No Unknown

Airport/airplane
 Adult congregate living facility (nursing, assisted living, or long-term care facility)
 K-12 school Name: _____ Role: _____
 College/university Name: _____ Role: _____
 Childcare center Name: _____ Role: _____
 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, nCoV ID(s) _____
 No, this person was an international case and contact occurred abroad
 Unknown if U.S. or international case
 Is this case part of an outbreak?
 Yes, specify outbreak name: _____ No Unknown
 Other exposures, specify: _____
 Unknown exposures in the 14 days prior to illness onset

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ___/___/___

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Clinical course, symptoms, past medical history, and social history

Collected from (check all that apply): <input type="checkbox"/> Patient interview <input type="checkbox"/> Medical record review																																													
Symptoms present during course of illness: <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Unknown	If case was symptomatic: What was the onset date? Onset date (MM/DD/YYYY): ___/___/___ <input type="checkbox"/> Unknown symptom onset date																																												
Did the patient's symptoms resolve? Date of symptom resolution (MM/DD/YYYY): ___/___/___ <input type="checkbox"/> No, still symptomatic <input type="checkbox"/> Symptoms resolved, unknown date <input type="checkbox"/> Unknown if symptoms resolved																																													
Did the patient develop pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the patient have acute respiratory distress syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the patient have an abnormal chest X-ray? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A, no chest X-ray done Did the patient have another diagnosis/etiology for their illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the patient have an abnormal EKG? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A, no EKG done	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 Was the disclosure authorized by the case or their guardian? <input type="checkbox"/> Yes, obtained written HIPAA Authorization Form <input type="checkbox"/> HIPAA Exception, no authorization obtained (uncooperative case/guardian) <input type="checkbox"/> HIPAA Exception, obtained verbal authorization <input type="checkbox"/> HIPAA Exception, no authorization obtained (unable to reach case/guardian)																																												
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Other underlying condition or risk behavior, specify: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk																																													

Vaccination

Did the patient ever receive COVID-19 vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Vaccination doses prior to onset: _____ Date of last dose prior to illness onset: _____/_____/_____	Vaccine History Comments
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SARS-CoV-2 Testing (approved by FDA or other designated authority)

Test	Pos	Neg	Indet./Inconc.	Pend.	Not Done
Molecular amplification test (RT PCR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serologic test	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>

Specimens for CoV-19 Testing

Specimen ID
1) _____
2) _____
3) _____

Additional Comments or Notes