

.....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

<p>What is the current status of this person?</p> <input type="checkbox"/> PUI, testing pending* <input type="checkbox"/> PUI, tested negative* <input type="checkbox"/> Presumptive case (positive local test), confirmatory testing pending† <input type="checkbox"/> Presumptive case (positive local test), confirmatory tested negative† <input type="checkbox"/> Laboratory-confirmed case† *Testing performed by state, local, or CDC lab. †At this time, all confirmatory testing occurs at CDC <p>Report date of PUI to CDC (MM/DD/YYYY): ___/___/___</p> <p>Report date of case to CDC (MM/DD/YYYY): ___/___/___</p> <p>County of residence: _____ State of residence: _____</p>	<p>Ethnicity:</p> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Not specified <p>Sex:</p> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	<p>Date of first positive specimen collection (MM/DD/YYYY): ___/___/___</p> <input type="checkbox"/> Unknown <input type="checkbox"/> N/A <p>Did the patient develop pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No</p> <p>Did the patient have acute respiratory distress syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No</p> <p>Did the patient have another diagnosis/etiology for their illness? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No</p> <p>Did the patient have an abnormal chest X-ray? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No</p>	<p>Was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If yes, admission date 1 ___/___/___ (MM/DD/YYYY)</p> <p>If yes, discharge date 1 ___/___/___ (MM/DD/YYYY)</p> <p>Was the patient admitted to an intensive care unit (ICU)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>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) _____</p> <p>Did the patient receive ECMO? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Did the patient die as a result of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Date of death (MM/DD/YYYY): ___/___/___ <input type="checkbox"/> Unknown date of death</p>															
<p>Race (check all that apply):</p> <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: _____																		
<p>Date of birth (MM/DD/YYYY): ___/___/___ Age: _____ Age units(yr/mo/day): _____</p>																		
<p>Symptoms present during course of illness:</p> <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Unknown	<p>If symptomatic, onset date (MM/DD/YYYY): ___/___/___ <input type="checkbox"/> Unknown</p>	<p>If symptomatic, date of symptom resolution (MM/DD/YYYY): ___/___/___</p> <input type="checkbox"/> Still symptomatic <input type="checkbox"/> Unknown symptom status <input type="checkbox"/> Symptoms resolved, unknown date																
<p>Is the patient a health care worker in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>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</p> <p>In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):</p> <table style="width: 100%;"> <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> <p>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</p>				<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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<p>Under what process was the PUI or case first identified? (check all that apply): <input type="checkbox"/> Clinical evaluation leading to PUI determination</p> <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: _____																		



CDC 2019-nCoV ID:

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

Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form

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/intellectual disability	<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	State Lab Tested	State Lab Result	Sent to CDC	CDC Lab Result
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: _____