

.....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 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? <input type="checkbox"/> Lab-confirmed case* <input type="checkbox"/> Probable case If probable, select reason for case classification: <input type="checkbox"/> Meets clinical criteria AND epidemiologic evidence with no confirmatory lab testing* <input type="checkbox"/> Meets presumptive lab evidence [±] AND either clinical criteria OR epidemiologic evidence <input type="checkbox"/> 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) <input type="checkbox"/> Clinical evaluation <input type="checkbox"/> Routine surveillance <input type="checkbox"/> Contact tracing of case patient <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> EpiX notification of travelers. If yes, DGMQID: _____ <input type="checkbox"/> Unknown Report date of case to CDC (MM/DD/YYYY): ___/___/___ Date of first positive specimen collection (MM/DD/YYYY): ___/___/___ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
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Hospitalization, ICU, and Death Information

Was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, admission date 1 _____ discharge date 1 _____ ___/___/___ (MM/DD/YYYY) ___/___/___	If hospitalized, was a translator required? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify which language: _____	Was the patient admitted to an intensive care unit (ICU)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, admission date 1 _____ discharge date 1 _____ ___/___/___ (MM/DD/YYYY) ___/___/___
Did the patient die as a result of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date of death (MM/DD/YYYY): ___/___/___ <input type="checkbox"/> Unknown date		

Case Demographics

Date of birth (MM/DD/YYYY): ___/___/___ Age: _____ Age units (yr/mo/day): _____ State of residence: _____ County of residence: _____ Does this case have any tribal affiliation? <input type="checkbox"/> yes Tribe name(s): _____ Enrolled member? <input type="checkbox"/> yes	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Female <input type="checkbox"/> Unknown If female, currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown	Race (check all that apply): <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____
Which would best describe where the patient was staying at the time of illness onset? <input type="checkbox"/> House/single family home <input type="checkbox"/> Hotel/motel <input type="checkbox"/> Nursing home/assisted living facility <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Mobile home <input type="checkbox"/> Apartment <input type="checkbox"/> Long term care facility <input type="checkbox"/> Acute care inpatient facility <input type="checkbox"/> Correctional facility <input type="checkbox"/> Group home <input type="checkbox"/> Homeless shelter <input type="checkbox"/> Outside, in a car, or other location not meant for human habitation <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown			

Healthcare Worker Information

Is the patient a health care worker in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, what is their occupation (type of job)? <input type="checkbox"/> Physician <input type="checkbox"/> Respiratory therapist <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Nurse <input type="checkbox"/> Environmental services <input type="checkbox"/> Unknown	If yes, what is their job setting? <input type="checkbox"/> Hospital <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Long-term care facility <input type="checkbox"/> Nursing home/assisted living facility <input type="checkbox"/> Unknown
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Exposure Information

In the 14 days prior to illness onset , did the patient have any of the following exposures (check all that apply): <input type="checkbox"/> Domestic travel (outside state of normal residence). Specify state(s): _____ <input type="checkbox"/> International travel. Specify country(s): _____ <input type="checkbox"/> Cruise ship or vessel travel as passenger or crew member. Specify name of ship: _____ <input type="checkbox"/> Workplace If yes, is the workplace critical infrastructure (e.g., healthcare setting, grocery store)? <input type="checkbox"/> Yes, specify workplace setting: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Airport/airplane <input type="checkbox"/> Adult congregate living facility (nursing, assisted living, or long-term care facility) <input type="checkbox"/> School/university/childcare center <input type="checkbox"/> Correctional facility <input type="checkbox"/> Community event/mass gathering <input type="checkbox"/> Animal with confirmed or suspected COVID-19. Specify animal: _____ <input type="checkbox"/> Other exposures, specify: _____ <input type="checkbox"/> Unknown exposures in the 14 days prior to illness onset		<input type="checkbox"/> 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? <input type="checkbox"/> Household contact <input type="checkbox"/> Community-associated contact <input type="checkbox"/> Healthcare-associated contact (patient, visitor, or healthcare worker) Was this person a U.S. case? <input type="checkbox"/> Yes, nCoV ID(s) _____, _____, _____ <input type="checkbox"/> No, this person was an international case and contact occurred abroad <input type="checkbox"/> Unknown if U.S. or international case Is this case part of an outbreak? <input type="checkbox"/> Yes, specify outbreak name: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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 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 have acute respiratory distress syndrome? <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 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 receive ECMO? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Did the patient have another diagnosis/etiology for their illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

If symptomatic, which of the following did the patient experience during their illness?					
Fever >100.4F (38C) ^c	<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
Subjective fever (felt feverish)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Wheezing	<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	Shortness of breath (dyspnea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Rigors	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Difficulty breathing	<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	Chest pain	<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	Nausea or vomiting	<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	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
New olfactory and taste disorder(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Diarrhea (≥3 loose stools/24hr period)	<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	Other, specify: _____, _____, _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk		

Did they have any underlying medical conditions and/or risk behaviors? <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"/> Unk	Immunosuppressive condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Autoimmune condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Severe obesity (BMI ≥40)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Current smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cardiovascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Former smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chronic Renal disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Substance abuse or misuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chronic Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Disability (neurologic, neurodevelopmental, intellectual, physical, vision or hearing impairment) If yes, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chronic Lung disease (asthma/emphysema/COPD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk		
Other chronic diseases If yes, specify: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Psychological/psychiatric condition If yes, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Other underlying condition or risk behavior, specify: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk		

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