Coronavirus Disease 2019 (COVID-19) Case Report Form

Local health departments should submit this report to the regional health department.
Regional health departments should fax this report to 512-776-7616.

Today's date__________ **NNDSS local record ID/Case ID[1] _________**
Case type: ☐ Confirmed **Collected from** (check all that apply): ☐ Patient interview
☐ Probable ☐ Medical records

Patient's Name:	Address:	City:	County:	State:	Zip Code:
Date of Birth:	Home Phone:	Cell Phone:	Email:		

STATE ID:	Date of Report:	City:	County:	State:
Investigator's name:	Phone:	Email:	Investigation Start Date:	
Physician's name:	Phone/Pager:			
Reporter's Name:	Phone:	Email:		

PATIENT DEMOGRAPHIC INFORMATION

Sex: ☐ M ☐ F **Age**: _______ ☐ yr ☐ mo ☐ days **Residency:** ☐ U.S. resident ☐ Non-U.S. resident, country: _______________________
Residence Type: ☐Private residence ☐Homeless ☐Homeless shelter ☐ Assisted living facility ☐ Long term acute care
☐ Long term care facility ☐ Rehabilitation facility ☐Hospice ☐ State Supported Living facility ☐ Military base
☐ Quarantine facility, military or other ☐Hotel ☐Jail ☐Prison ☐Detention Facility ☐Unknown
☐Other residence type: ____________________
Race: ☐White ☐Black ☐Asian ☐Pacific Islander ☐Native American/Alaskan ☐Unknown ☐Other: ____________________________
Hispanic: ☐Yes ☐No ☐Unknown
Occupation: __________________________________ ☐ **Unemployed** ☐**Student, Name of School:__________________________**

CASE CRITERIA

Date of symptom onset _____________________ ☐ **Asymptomatic**
Does the patient have the following signs and symptoms (check all that apply)?
☐ Fever[2] ☐ Cough ☐ Sore throat ☐ Shortness of breath
Does the patient have these additional signs and symptoms (check all that apply)?
☐ Chills ☐ Headache ☐ Muscle aches ☐ Vomiting ☐ Abdominal pain ☐ Diarrhea ☐ New olfactory and taste disorder(s)
☐ Other, Specify _______________

In the 14 days before symptom onset, did the patient:

Travel outside their city of residence? If yes, list destinations and dates*: Date arrived (MM/DD/YY) Date left (MM/DD/YY) 1. ____________________________ _____________ _______________ 2. ____________________________ _____________ _______________ 3. ____________________________ _____________ _______________ *Please list any additional travel destinations or information in the comments section.	☐ Y ☐ N ☐ Unknown
Have close contact[3] with a person who is under investigation for COVID-19?	☐ Y ☐ N ☐ Unknown
Have close contact[3] with a laboratory-confirmed COVID-19 case? Was the case ill at the time of contact?	☐ Y ☐ N ☐ Unknown ☐ Y ☐ N ☐ Unknown

Is the case a U.S. case?	☐ Y ☐ N ☐ Unknown
Is the case an international case?	☐ Y ☐ N ☐ Unknown
In which country was the case diagnosed with COVID-19? ________________________________	
No known exposure history (suspected community transmission) Only check Y if you have been able to confirm that the patient has no exposure risk factors such as travel, contact with a confirmed or suspected case, providing care for a confirmed case, etc. If you are unable to ascertain exposure history, check Unknown.	☐ Y ☐ N ☐ Unknown

ADDITIONAL PATIENT INFORMATION

Is the patient a healthcare worker? ☐ Y ☐ N ☐ Unknown

Have history of being in a healthcare facility (as a patient, worker, or visitor)? ☐ Y ☐ N ☐ Unknown

Provide care for a COVID-19 patient? ☐ Y ☐ N ☐ Unknown

Is patient a member of a cluster of patients with severe acute respiratory illness (e.g., fever and pneumonia requiring hospitalization) of unknown etiology in which COVID-19 is being evaluated? ☐ Y ☐ N ☐ Unknown

Diagnosis (select all that apply): Pneumonia (clinical or radiologic) ☐ Y ☐ N Acute respiratory distress syndrome ☐ Y ☐ N

Co-morbid conditions (check all that apply): ☐ None ☐ Unknown ☐ Pregnant ☐ Diabetes ☐ Cardiac disease ☐ Hypertension ☐ Chronic pulmonary disease ☐ Chronic kidney disease ☐ Chronic liver disease ☐ Immunocompromised ☐ Other, specify:____

Is/was the patient: Hospitalized? ☐ Y, admit date ________ ☐ N **Admitted to ICU?** ☐ Y ☐ N

Date Admitted to ICU: ________ **Intubated?** ☐ Y ☐ N ☐ Unk **On ECMO?** ☐ Y ☐ N ☐ Unk

On mechanical ventilation? ☐ Y ☐ N ☐ Unk **If yes, total days on mechanical ventilation?** _________

Patient died? ☐ Y ☐ N **If yes, date of death**: ________

Discharged from hospital? ☐ Y, DC date_______ ☐ N **Is the patient isolated at home?** ☐ Y ☐ N

Does the patient have another diagnosis/etiology for their respiratory illness? ☐ Y, Specify______________ ☐ N ☐ Unknown

Additional Comments (smoking status, other comorbidities, potential contacts/places of exposure, etc.)**:**

Where did COVID-19 testing occur? ☐ **Commercial or Hospital Lab Please specify: ________________________________**
☐ **Texas DSHS Laboratory Response Network (LRN) Lab Please specify: _____________**
☐ **DSHS-Austin Lab**

RESPIRATORY DIAGNOSTIC RESULTS

Test	Pos	Neg	Pending	Not done
Influenza rapid Ag ☐ A ☐ B	☐	☐	☐	☐
Influenza PCR ☐ A ☐ B	☐	☐	☐	☐
RSV	☐	☐	☐	☐
H. metapneumovirus	☐	☐	☐	☐
Parainfluenza (1-4)	☐	☐	☐	☐
Adenovirus	☐	☐	☐	☐

Test	Pos	Neg	Pending	Not done
Rhinovirus/enterovirus	☐	☐	☐	☐
Coronavirus (OC43, 229E, HKU1, NL63)	☐	☐	☐	☐
M. pneumoniae	☐	☐	☐	☐
C. pneumoniae	☐	☐	☐	☐
Other, Specify_________	☐	☐	☐	☐

COVID-19 TESTING (*complete information for all that apply*)

Test type	Specimen type	Specimen ID	Test Result	Date collected	Date Resulted	Lab Name	Commercial	Public Health
RT-PCR	☐ NP Swab ☐ OP Swab ☐ Serum ☐ BAL fluid ☐ Tracheal Aspirate ☐ Sputum ☐ Stool ☐ Other, specify: _______________		☐Pos ☐Neg ☐Indet ☐Not done				☐	☐
Viral Culture	☐ NP Swab ☐ OP Swab ☐ Serum ☐ BAL fluid ☐ Tracheal Aspirate ☐ Sputum ☐ Stool ☐ Other, specify: _______________		☐Pos ☐Neg ☐Indet ☐Not done				☐	☐
Serology ☐ IgM ☐ IgG	☐ Blood ☐ Other, specify: _______________		☐Pos ☐Neg ☐Indet ☐Not done				☐	☐
Commercial rapid diagnostic test	☐ NP Swab ☐ OP Swab ☐ Other, specify: _______________		☐Pos ☐Neg ☐Indet ☐Not done				☐	☐
Postmortem testing	☐ NP Swab ☐ OP Swab ☐ Other, specify: _______________		☐Pos ☐Neg ☐Indet ☐Not done				☐	☐
Other testing Specify:	☐ NP Swab ☐ OP Swab ☐ Serum ☐ BAL fluid ☐ Tracheal Aspirate ☐ Sputum ☐ Stool ☐ Other, specify: _______________		☐Pos ☐Neg ☐Indet ☐Not done				☐	☐

[1] *For NNDSS reporters, use GenV2 or NETSS patient identifier.*

[2] *Fever may not be present in some patients, such as those who are very young, elderly, immunosuppressed, or taking certain medications. Clinical judgement should be used to guide testing of patients in such situations*

[3] Close contact is defined as—

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a health care waiting area or room with a COVID-19 case

– or –

b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met"

See CDC's updated guidance for infection control on their website for specific relevant guidance: https://cdc.gov/coronavirus

Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with 2019-nCoV (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to those exposed in health care settings.

State/Local Close Contact ID: ______________________________

COVID-19 Contact Interview
Local health departments should submit this report to the regional health department.
Regional health departments should fax this report to 512-776-7616.

Instructions: This contact form is for use with COVID-19 investigations necessitating contact investigation or follow-up. However, based on the local situation, available resources, and competing priorities, LHDs and PHRs may prioritize contact investigations to focus on exposures to populations at higher risk for severe illness. In some circumstances, LHDs and PHRs may consider suspending contact investigations altogether. Prior to interview with contact, please note the following information about the confirmed case that identified this contact:

Confirmed Case Last:_______________________________________ First: ____________________________________

Date of symptom onset: _________________ (MM/DD/YYYY) ☐ Asymptomatic

Date of last symptom: _________________ (MM/DD/YYYY) ☐ Still symptomatic

Date of contact's last exposure to confirmed case ____________________ (MM/DD/YYYY)
☐ Continued exposure

Interviewer information

Date interview completed: _________________(MM/DD/YYYY) Interviewer telephone: _____________________

Interviewer Name: Last:_______________ First:__________________ Organization/affiliation: ________________

Who is providing information for this form?

☐ Contact ☐ Parent/guardian

☐ Other, specify name: _________________ Relationship to contact: _________________________

Contact's primary language: ____________________ Was this form administered via a translator? ☐ Yes ☐ No

Close contact's information

Last Name: ____

First Name: ____

Current Address: ____________________________ City: _______________ State: ______________________ Zip: ______________________

Phone: _______________________ Is address the same as the case? ☐ Yes ☐ No

Close contact's demographic information

1. Date of birth:___________________(MM/DD/YYYY)
2. Age: ________ ☐ years ☐ month ☐ days
3. Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Not Specified
4. Race: ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Native Hawaiian/Other Pacific Islander ☐ Other, specify:____________________ ☐ Unknown
5. Sex: ☐ Male ☐ Female ☐ Unknown ☐ Other

Symptoms

6. Since your date of last exposure to the confirmed case, have you experienced any of the following symptoms? ☐ No symptoms

Symptom	Symptom Present?			Date of Onset	Date Resolved	Not
	Yes	No	Unk	(MM/DD/YYYY)		Resolved
Fever >100.0°F (37.8°C)	☐	☐	☐			☐
Subjective fever (felt feverish)	☐	☐	☐			☐
Chills	☐	☐	☐			☐
Muscle aches (myalgia)	☐	☐	☐			☐
Runny nose (rhinorrhea)	☐	☐	☐			☐
Sore throat	☐	☐	☐			☐
Cough (new onset or worsening of chronic cough)	☐	☐	☐			☐
Shortness of breath (dyspnea)	☐	☐	☐			☐
Nausea/Vomiting	☐	☐	☐			☐
Headache	☐	☐	☐			☐
Abdominal pain	☐	☐	☐			☐
Diarrhea (≥3 loose/looser than normal stools/24hr period)	☐	☐	☐			☐
New olfactory and taste disorder	☐	☐	☐			☐
Other, specify:	☐	☐	☐			☐

Past Medical History

7. Do you have any pre-existing medical conditions? ☐ Yes ☐ No ☐ Unknown

Condition				
Chronic Lung Disease (asthma/emphysema/COPD)	☐Yes	☐No	☐ Unk	
Diabetes Mellitus	☐Yes	☐No	☐ Unk	
Cardiovascular disease	☐Yes	☐No	☐ Unk	
Chronic Renal disease	☐Yes	☐No	☐ Unk	
Chronic Liver disease	☐Yes	☐No	☐ Unk	
Immunocompromised Condition	☐Yes	☐No	☐ Unk	
Neurologic/neurodevelopmental disorder	☐Yes	☐No	☐ Unk	Specify:
Other chronic diseases	☐Yes	☐No	☐ Unk	Specify:
If female, pregnant or ≤2 weeks postpartum	☐Yes	☐No	☐ Unk	
Current smoker, including vaping	☐Yes	☐No	☐Unk	Specify:
Former smoker, including vaping	☐Yes	☐No	☐Unk	Specify:

State/Local Close Contact ID: ______________________________

Exposures to confirmed case

8. What is your relationship to the confirmed case? (*select all that apply*)

- ☐ Spouse/Partner
- ☐ Child
- ☐ Parent
- ☐ Other Family
- ☐ Friend
- ☐ Healthcare Worker
- ☐ Co-worker
- ☐ Classmate
- ☐ Roommate
- ☐ Other (specify):_______________________________________

9. Where were you exposed to the confirmed case? (*select all that apply*)

- ☐ Household
- ☐ Healthcare setting
- ☐ Work
- ☐ Daycare
- ☐ School/University
- ☐ Transit
- ☐ Rideshare
- ☐ Hotel
- ☐ Community
- ☐ Other

Specify Location(s) (Name and Address):

10. During the period of ***potential exposure*** (defined as the confirmed case's date of symptom onset through your date of last contact with the confirmed case), did you…….?

Exposure	**Answer**	**Start date** (date exposure first occurred) (MM/DD/YYYY)	**End date** (date exposure last occurred) (MM/DD/YYYY)	**Number of occurrences** (number of times the exposure occurred)	**Total cumulative duration of occurrence(s)** (specify unit)
…have face to face contact with the confirmed case?	☐ Yes ☐ No ☐ Unknown				________ ☐ minutes ☐ hours ☐ days
…have direct physical contact with the confirmed case? (e.g., hug, shake hands, etc.)	☐ Yes ☐ No ☐ Unknown				________ ☐ minutes ☐ hours ☐ days
…physically within 6 feet of the confirmed case?	☐ Yes ☐ No ☐ Unknown				________ ☐ minutes ☐ hours ☐ days

State/Local Close Contact ID: ______________________________

Exposure	Answer	**Start date** (date exposure first occurred) (MM/DD/YYYY)	**End date** (date exposure last occurred) (MM/DD/YYYY)	**Number of occurrences** (number of times the exposure occurred)	**Total cumulative duration of occurrence(s)** (specify unit)
…within 6 feet while the confirmed case was coughing or sneezing?	☐ Yes ☐ No ☐ Unknown				________ ☐ minutes ☐ hours ☐ days
…take an object handed from or handled by the confirmed case? (e.g., pen, paper, food, utensil, etc.)	☐ Yes ☐ No ☐ Unknown				________ ☐ minutes ☐ hours ☐ days
…in the same room as the confirmed case?	☐ Yes ☐ No ☐ Unknown				________ ☐ minutes ☐ hours ☐ days
…sleep in the same room as the confirmed case during the time he/she was ill?	☐ Yes ☐ No ☐ Unknown				________ ☐ minutes ☐ hours ☐ days
… share a bathroom with the confirmed case during the time he/she was ill?	☐ Yes ☐ No ☐ Unknown				________ ☐ minutes ☐ hours ☐ days
… prepare food with the confirmed case during the time he/she was ill?	☐ Yes ☐ No ☐ Unknown				________ ☐ minutes ☐ hours ☐ days
…travel in the same vehicle (car, bus, airplane), sitting within 6 feet of the confirmed case?	☐ Yes ☐ No ☐ Unknown				________ ☐ minutes ☐ hours ☐ days

State/Local Close Contact ID: ______________________________

A calendar has been provided to use as a memory aid to identify times/places that the case and contact interacted.

Jan 2020						
Su	Mo	Tu	We	Th	Fri	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Feb 2020						
Su	Mo	Tu	We	Th	Fri	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29

March 2020						
Su	Mo	Tu	We	Th	Fri	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

April 2020						
Su	Mo	Tu	We	Th	Fri	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

May 2020						
Su	Mo	Tu	We	Th	Fri	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

June 2020						
Su	Mo	Tu	We	Th	Fri	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				