CDC 2019-nCoV ID: _____

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

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

Patient address _____ Patient phone _____ Patient email _____

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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]	

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

Interviewer Information

Name of Interviewer: Last:	First:	Telephone:
Affiliation/Organization:		Email:

Case Classification and Identification

What is the current status of this person?
☐ Lab-confirmed case* ☐ Probable case

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

Sex:
☐ Male ☐ Other
☐ Female ☐ Unknown

If female, currently pregnant?
☐ Yes ☐ No ☐ Unknown

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Unknown

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

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)
☐ School/university/childcare center
☐ Correctional facility
☐ Community event/mass gathering
☐ Animal with confirmed or suspected COVID-19. Specify animal: _____
☐ Other exposures, specify: _____
☐ Unknown exposures in the 14 days prior to illness onset

☐ 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

CDC 2019-nCoV ID: ☐

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

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

Symptoms present during course of illness:
- ☐ Symptomatic
- ☐ Asymptomatic
- ☐ Unknown

If case was symptomatic:

What was the onset date?
Onset date (MM/DD/YYYY): __/__/____
☐ Unknown symptom onset date

Did the patient's symptoms resolve?
Date of symptom resolution (MM/DD/YYYY): __/__/_____
- ☐ No, still symptomatic
- ☐ Symptoms resolved, unknown date
- ☐ Unknown if symptoms resolved

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 ☐ N/A, no chest X-ray done

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

Did the patient have an abnormal EKG?
☐ Yes ☐ No ☐ Unknown ☐ N/A, no EKG done

Did the patient receive mechanical ventilation (MV)/intubation?
☐ Yes ☐ No ☐ Unknown
If yes, total days with MV (days)

Did the patient receive ECMO?
☐ Yes ☐ No ☐ Unknown

If symptomatic, which of the following did the patient experience during their illness?

Fever >100.4F (38C)[c]	☐ Yes	☐ No	☐ Unk	Cough (new onset or worsening of chronic cough)	☐ Yes	☐ No	☐ Unk
Subjective fever (felt feverish)	☐ Yes	☐ No	☐ Unk	Wheezing	☐ Yes	☐ No	☐ Unk
Chills	☐ Yes	☐ No	☐ Unk	Shortness of breath (dyspnea)	☐ Yes	☐ No	☐ Unk
Rigors	☐ Yes	☐ No	☐ Unk	Difficulty breathing	☐ Yes	☐ No	☐ Unk
Muscle aches (myalgia)	☐ Yes	☐ No	☐ Unk	Chest pain	☐ Yes	☐ No	☐ Unk
Runny nose (rhinorrhea)	☐ Yes	☐ No	☐ Unk	Nausea or vomiting	☐ Yes	☐ No	☐ Unk
Sore throat	☐ Yes	☐ No	☐ Unk	Abdominal pain	☐ Yes	☐ No	☐ Unk
New olfactory and taste disorder(s)	☐ Yes	☐ No	☐ Unk	Diarrhea (≥3 loose stools/24hr period)	☐ Yes	☐ No	☐ Unk
Headache	☐ Yes	☐ No	☐ Unk	Other, specify: _____, _____, _____	☐ Yes	☐ No	☐ Unk
Fatigue	☐ Yes	☐ No	☐ Unk				

Did they have any underlying medical conditions and/or risk behaviors? ☐ Yes ☐ No ☐ Unknown

Diabetes Mellitus	☐ Yes	☐ No	☐ Unk	Immunosuppressive condition	☐ Yes	☐ No	☐ Unk
Hypertension	☐ Yes	☐ No	☐ Unk	Autoimmune condition	☐ Yes	☐ No	☐ Unk
Severe obesity (BMI ≥40)	☐ Yes	☐ No	☐ Unk	Current smoker	☐ Yes	☐ No	☐ Unk
Cardiovascular disease	☐ Yes	☐ No	☐ Unk	Former smoker	☐ Yes	☐ No	☐ Unk
Chronic Renal disease	☐ Yes	☐ No	☐ Unk	Substance abuse or misuse	☐ Yes	☐ No	☐ Unk
Chronic Liver disease	☐ Yes	☐ No	☐ Unk	Disability (neurologic, neurodevelopmental, intellectual, physical, vision or hearing impairment) If yes, specify: _____	☐ Yes	☐ No	☐ Unk
Chronic Lung disease (asthma/emphysema/COPD)	☐ Yes	☐ No	☐ Unk				
Other chronic diseases If yes, specify: _____	☐ Yes	☐ No	☐ Unk				
Other underlying condition or risk behavior, specify: _____	☐ Yes	☐ No	☐ Unk	Psychological/psychiatric condition If yes, specify: _____	☐ Yes	☐ No	☐ 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)	☐	☐	☐	☐	☐
Serologic test	☐	☐	☐	☐	☐
Other (specify): _____	☐	☐	☐	☐	☐

Specimens for CoV-19 Testing

Specimen ID
1) _____
2) _____
3) _____

Additional Comments or Notes