

.....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

What is the current status of this person? Patient under investigation (PUI) Laboratory-confirmed case Report date of PUI to CDC (MM/DD/YYYY): ____/____/____ Report date of case to CDC (MM/DD/YYYY): ____/____/____ County of residence: _____ State of residence: _____		Ethnicity: Hispanic/Latino Non-Hispanic/Latino Not specified Sex: Male Female Unknown Other	Date of first positive specimen collection (MM/DD/YYYY): ____/____/____ Unknown N/A Did the patient develop pneumonia? Yes Unknown No Did the patient have acute respiratory distress syndrome? Yes Unknown No Did the patient have another diagnosis/etiology for their illness? Yes Unknown No Did the patient have an abnormal chest X-ray? Yes Unknown No	Was the patient hospitalized? Yes No Unknown If yes, admission date 1 ____/____/____ (MM/DD/YYYY) If yes, discharge date 1 ____/____/____ (MM/DD/YYYY) Was the patient admitted to an intensive care unit (ICU)? Yes No Unknown 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 Did the patient die as a result of this illness? Yes No Unknown Date of death (MM/DD/YYYY): ____/____/____ Unknown date of death			
Race (check all that apply): Asian American Indian/Alaska Native Black Native Hawaiian/Other Pacific Islander White Unknown Other, specify: _____							
Date of birth (MM/DD/YYYY): ____/____/____ Age: _____ Age units(yr/mo/day): _____							
Symptoms present during course of illness: Symptomatic Asymptomatic Unknown	If symptomatic, onset date (MM/DD/YYYY): ____/____/____ Unknown	If symptomatic, date of symptom resolution (MM/DD/YYYY): ____/____/____ Still symptomatic Unknown symptom status Symptoms resolved, unknown date					
Is the patient a health care worker in the United States? Yes No Unknown Does the patient have a history of being in a healthcare facility (as a patient, worker or visitor) in China? Yes No Unknown In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply): <table style="width: 100%;"> <tr> <td style="width: 33%;"> Travel to Wuhan Travel to Hubei Travel to mainland China Travel to other non-US country specify: _____ Household contact with another lab confirmed COVID-19 case-patient </td> <td style="width: 33%;"> Community contact with another lab-confirmed COVID-19 case-patient Any healthcare contact with another lab-confirmed COVID-19 case-patient Patient Visitor HCW Animal exposure </td> <td style="width: 33%;"> Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology Other, specify: _____ Unknown </td> </tr> </table>					Travel to Wuhan Travel to Hubei Travel to mainland China Travel to other non-US country specify: _____ Household contact with another lab confirmed COVID-19 case-patient	Community contact with another lab-confirmed COVID-19 case-patient Any healthcare contact with another lab-confirmed COVID-19 case-patient Patient Visitor HCW Animal exposure	Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology Other, specify: _____ Unknown
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If the patient had contact with another COVID-19 case, was this person a U.S. case? Yes, nCoV ID of source case: _____ No Unknown N/A							
Under what process was the PUI or case first identified? (check all that apply): Clinical evaluation leading to PUI determination Contact tracing of case patient Routine surveillance EpiX notification of travelers; if checked, DGMQID _____ Unknown Other, specify: _____							

Symptoms, clinical course, past medical history and social history

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

CDC 2019-nCoV ID:

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

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During this illness, did the patient experience any of the following symptoms?	Symptom Present?		
Fever >100.4F (38C) ^c	Yes	No	Unk
Subjective fever (felt feverish)	Yes	No	Unk
Chills	Yes	No	Unk
Muscle aches (myalgia)	Yes	No	Unk
Runny nose (rhinorrhea)	Yes	No	Unk
Sore throat	Yes	No	Unk
Cough (new onset or worsening of chronic cough)	Yes	No	Unk
Shortness of breath (dyspnea)	Yes	No	Unk
Nausea or vomiting	Yes	No	Unk
Headache	Yes	No	Unk
Abdominal pain	Yes	No	Unk
Diarrhea (≥3 loose/looser than normal stools/24hr period)	Yes	No	Unk
Other, specify: _____			

Pre-existing medical conditions?

Yes No Unknown

	Yes	No	Unknown	
Chronic Lung Disease (asthma/emphysema/COPD)	Yes	No	Unknown	
Diabetes Mellitus	Yes	No	Unknown	
Cardiovascular disease	Yes	No	Unknown	
Chronic Renal disease	Yes	No	Unknown	
Chronic Liver disease	Yes	No	Unknown	
Immunocompromised Condition	Yes	No	Unknown	
Neurologic/neurodevelopmental	Yes	No	Unknown	(If YES, specify) _____
Other chronic diseases	Yes	No	Unknown	(If YES, specify) _____
If female, currently pregnant	Yes	No	Unknown	
Current smoker	Yes	No	Unknown	
Former smoker	Yes	No	Unknown	

Respiratory Diagnostic Testing

Test	Pos	Neg	Pend.	Not done
Influenza rapid Ag A B				
Influenza PCR A B				
RSV				
H. metapneumovirus				
Parainfluenza (1-4)				
Adenovirus				
Rhinovirus/enterovirus				
Coronavirus (OC43, 229E, HKU1, NL63)				
M. pneumoniae				
C. pneumoniae				
Other, Specify: _____				

Specimens for COVID-19 Testing

Specimen Type	Specimen ID	Date Collected	Sent to CDC	State Lab Tested
NP Swab				
OP Swab				
Sputum				
Other, Specify: _____				

Additional State/local Specimen IDs: _____

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).