Institute of Epidemiology, Disease Control and Research (IEDCR)

COVID-19Suspected Case RecordForm

IDNo: Date:...../...../2020

Institute/Hospital:			
Department:			
Unit:	Unit Head:		
Ward:	Ward/Cabin:		
Name of Patient:			
Age:	.....Years or if <5 years ..... Month	Sex:	□Male □Female
Occupation:	Phone/Cell No:		
Address:		Emergency Contact Number	
Email address:			
Referred by:			

COVID-19 Suspect Criteria: Give (√) to select

Symptom	Yes/No
1. Fever (≥38°C or100.4°F)	□**Yes** □**No**
2. Headache	□**Yes** □**No**
3. Cough	□**Yes** □**No**
4. Breathlessness	□**Yes** □**No**
5. Others (Specify)	

6. Clinical or radiological evidence of Pneumonia or severe Acute Respiratory Distress Syndrome □**Yes** □**No** □**Unknown**
7. **Travel history** in 14 days before illness onset. □**Yes** □**No** □**Unknown**
   If yes, **Country**.....
   Date of departure from the place.....
8. Has the person **had contact with a confirmed case** in the 14 days prior to symptom onset?
   □**Yes** □**No** □**Unknown**
9. Has the person **visited any health care facility** in the 14 days prior to symptom onset?
   □**Yes** □**No** □**Unknown**

Concurrent risk factors (Check all that apply): □COPD □Asthma □ Interstitial lung disease □DM □IHD □HTN □CKD □CLD □Malignant disease □On steroid therapy □Pregnancy □Others .....

Specimen: □Collected □ Not collected, if collected mention type:
□Nasal swab □ throat swab □Sputum □Tracheal aspirate □Serum
□Other:.....

If any remarks:

Interview Conducted by