

.....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: _____

Reporting health department: _____

Contact ID ^a: _____

Case state/local ID: _____

CDC 2019-nCoV ID: _____

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? ☐ PUI, testing pending* ☐ PUI, tested negative* ☐ Presumptive case (positive local test), confirmatory testing pending† ☐ Presumptive case (positive local test), confirmatory tested negative† ☐ Laboratory-confirmed case† *Testing performed by state, local, or CDC lab. †At this time, all confirmatory testing occurs at CDC 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): ☐ Travel to Wuhan ☐ Community contact with another lab-confirmed COVID-19 case-patient ☐ Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology ☐ Travel to Hubei ☐ Any healthcare contact with another lab-confirmed COVID-19 case-patient ☐ Other, specify: _____ ☐ Travel to mainland China ☐ Patient ☐ Visitor ☐ HCW ☐ Unknown ☐ Travel to other non-US country specify: _____ ☐ Household contact with another lab-confirmed COVID-19 case-patient ☐ Animal exposure				
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: _____				

CDC 2019-nCoV ID:

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

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Symptoms, clinical course, past medical history and social history

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

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

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/intellectual disability	☐ 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	State Lab Tested	State Lab Result	Sent to CDC	CDC Lab Result
NP Swab			☐		☐	
OP Swab			☐		☐	
Sputum			☐		☐	
Other, Specify: _____			☐		☐	

Additional State/local Specimen IDs: _____