Kentucky Public Health
Prevent. Promote. Protect.

CDC 2019-nCoV ID:

Clear Form | Print | Save Copy

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

Patient first name | Patient last name | Date of birth (MM/DD/YYYY):

Address | City | State | Zip | Phone

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 Info

Name of Interviewer: | Phone: | Email:

Affiliation/Organization:

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:

☐ EpiX notification of travelers. If yes, DGMQID:

☐ Unknown

Report date of case to CDC (MM/DD/YYYY):

Date first positive specimen (MM/DD/YYYY):

☐ Unknown ☐ N/A

Hospitalization, ICU, and Death Information

Was the patient hospitalized?

☐ Yes ☐ No ☐ Unknown

If yes, Admission date:

Discharge date :

If hospitalized, was a translator required?

☐ Yes ☐ No ☐ Unknown

If yes, specify **language**:

Was the patient admitted to an intensive care unit (ICU)?

☐ Yes ☐ No ☐ Unknown

If yes, ICU admission date:

ICU Discharge date:

Did the patient die as a result of this illness?

☐ Yes ☐ No ☐ Unknown

If yes, date of death (MM/DD/YYYY):

☐ Date of death unknown date

Case Demographics

Date of Birth:

Age: | Age units (yr/mo/day):

Residence State: | County :

Does this case have any tribal affiliation? ☐ yes

Enrolled member? ☐ Yes

Tribe name(s):

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:

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

Yes 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

☐ Long-term care facility ☐ Nursing home/assisted living facility

☐ Unknown ☐ Other:

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 normal residence). Specify:

☐ International travel. Specify country(s):

☐ Cruise ship /vessel travel passenger or crew, Name of ship:

Workplace: Is the workplace **critical** infrastructure (e.g., healthcare , grocery store)? ☐ Yes ☐ No Unknown

Specify workplace setting:

☐ 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 :

☐ Unknown exposures in the 14 days prior to illness onset

☐ Other exposure, Specify

☐ Contact with 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 (patient, visitor, healthcare worker)

Was this person a U.S. case?

☐ If Yes, nCoV

☐ No, International case/contact occurred abroad

☐ Unknown if U.S. or international

case Is this case part of an outbreak?

☐ Yes, specify outbreak name:

☐ No ☐ Unknown

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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**? (MM/DD/YYYY):
☐ Unknown symptom onset date

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

Did the patient develop **pneumonia**? ☐ Yes ☐ No ☐ Unk

Did the patient have **acute respiratory distress syndrome**?
☐ Yes ☐ No ☐ Unk

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

Did the patient have an **abnormal chest X-ray**?
☐ Yes ☐ No ☐ Unk ☐ N/A, no chest X-ray done

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

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

Did the patient receive **ECMO**?
☐ Yes ☐ No ☐ Unk

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

	Y	N	Unknown
Fever	☐	☐	☐
Subjective fever (felt feverish)	☐	☐	☐
Chills	☐	☐	☐
Rigors	☐	☐	☐
Muscle aches (myalgia)	☐	☐	☐
Runny Nose (rhinorrhea)	☐	☐	☐
Sore throat	☐	☐	☐
New olfactory and taste disorder(s)	☐	☐	☐
Headache	☐	☐	☐
Fatigue	☐	☐	☐

	Y	N	Unknown
Cough (new onset or worsening of chronic cough)	☐	☐	☐
Wheezing	☐	☐	☐
Shortness of Breath (dyspena)	☐	☐	☐
Chest Pain	☐	☐	☐
Nausea or vomiting	☐	☐	☐
Abdominal Pain	☐	☐	☐
Diarrhea (>3 loose stools /24hr period)	☐	☐	☐

Other, Specifiy

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

	Y	N	Unk
Diabetes Mellitus	☐	☐	☐
Hypertension	☐	☐	☐
Severe obesity (BMI > 40)	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Chronic Renal disease	☐	☐	☐
Chronic Liver disease	☐	☐	☐
Chronic Lung Disease (asthma, emphysema, COPD)	☐	☐	☐

Other Chronic, specify:

Other underlying conditons/risk behavior, specify:

	Y	N	Unk
Immunosuppressive condition	☐	☐	☐
Autoimmune condition	☐	☐	☐
Current Smoker	☐	☐	☐
Former Smoker	☐	☐	☐
Substance abuse or misuse	☐	☐	☐

Disability (neurologic, neuro developmental, intellectual, physical, vision or hearing impairment) Specify:

Psychological/psychiatric condtion, Specify:

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