CDC 2019-nCoV ID: _____ ICPHD Specimen No. _____

Human Infection with 2019 Novel Coronavirus
Person Under Investigation (PUI) and Case Report Form

Patient Information

Name: Last _____ First_____ DOB (MM/DD/YYYY) _____

Physician Name: _____ Phone: _____ Pager or email: _____

Reporting Facility

Facility Name:_____ Person Completing the Form: _____

Reporting Health Department

Imperial County Public Health Department **Contact:** Karla Lopez/Paula Kriner **Phone:** (442) 265-1464 **Fax:** (442) 265-1477

Basic Information **Please complete non-shaded areas**

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
___/___/_____ (MM/DD/YYYY)
If yes, discharge date
__/___/_____ (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
- ☐ Black
- ☐ White
- ☐ Other, specify: _____
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Unknown

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
- ☐ 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

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: ☐

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Symptoms, clinical course, past medical history and social history

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						

Fax Completed Form To
(442) 265-1477