Washington State Department of Health

# COVID-19 Extended Form

**County**

Case name (last, first) _____ WDRS # _____

Birth date ___/___/___ Sex at birth ☐ F ☐ M ☐ Other Alternate name _____

Phone _____ Email _____

Address type ☐ Home ☐ Mailing ☐ Other ☐ Temporary ☐ Work

Street address _____

City/State/Zip/County _____

Residence type (incl. Homeless) _____ WA resident ☐ Yes ☐ No

## ADMINISTRATIVE

**Investigator** _____

LHJ Case ID (optional) _____

**LHJ notification date** ___/___/___

**Classification** ☐ Classification pending ☐ Confirmed
☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

**Investigation status**
☐ In progress
☐ Complete
☐ Complete – not reportable to DOH
☐ Unable to complete Reason _____

**Investigation start date** ___/___/___
Investigation complete date ___/___/___
**Case complete date** ___/___/___

Outbreak related ☐ Yes ☐ No
LHJ Cluster ID _____Cluster Name _____

Does this person have a previous Coronavirus Confirmed or Probable COVID-19 event? ☐ Yes ☐ No ☐ Unk
If yes: WDRS Event ID _____

## DEMOGRAPHICS

Age at symptom onset _____ ☐ Years ☐ Months
**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk
**Race** (check all that apply) ☐ Unk ☐ Amer Ind/AK Native
☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other _____
Primary language _____
Interpreter needed ☐ Yes ☐ No ☐ Unk
**Employed** ☐ Yes ☐ No ☐ Unk
**Occupation** _____
**Occupation type** ☐ Animal care worker
☐ Correctional facility worker ☐ Daycare worker
☐ Farm/dairy worker ☐ Food handler ☐ Healthcare worker
☐ Homeless shelter staff ☐ Migrant/seasonal farmworker
☐ Other
**Industry** _____ **Employer** _____
**Work site** _____ **City** _____
**Student/Day care** ☐ Yes ☐ No ☐ Unk
**Type of school** ☐ Preschool/day care ☐ K-12 ☐ College
☐Graduate School ☐ Vocational ☐ Online ☐ Other _____
**School name** _____
**School address** _____
**City/State/County** _____ Zip _____
Phone number _____ Teacher's name _____
Did the patient visit or stay in a healthcare setting (e.g., hospital, long term care/rehab/skilled nursing facility, clinic)
☐ Yes ☐ No ☐ Unk
Name of facility _____
*additional information to be filled out in WDRS
LTC associated ☐ Yes ☐ No ☐ Pending

## CARE COORDINATION

**Y N**
☐ ☐ Does the patient need essential resources or support to help them isolate at **home**
**Y N** Specify _____
☐ ☐ Would the patient like to be contacted by a care coordinator who can help them isolate or quarantine at home

## COMMUNICATIONS

Okay to talk to patient ☐ Yes ☐ Later ☐ Never
Date of interview attempt ___/___/___
Patient could not be interviewed ☐ Yes ☐ No
Alternate contact available ☐ Yes ☐ No
Alternate contact type ☐ Friend ☐ Other ☐ Parent/Guardian ☐ Spouse/Partner
Alternate contact name _____
Alternate contact phone number _____

## CLINICAL INFORMATION

Complainant ever symptomatic ☐ Yes ☐ No ☐ Unk Symptom Onset ___/___/___ ☐ Derived
Diagnosis date ___/___/___
Illness duration _____ ☐ Days ☐ Weeks ☐ Months ☐ Years Illness is still ongoing ☐ Yes ☐ No ☐ Unk

**Case Name (last, first)** _____ **WDRS #** _____

## Clinical Features

Y N Unk

- ☐ ☐ ☐ **Any fever, subjective or measured** **Temp measured?** ☐ Yes ☐ No **Highest measured temp** _____ºF
- ☐ ☐ ☐ Chills or rigors
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Myalgia (muscle aches or pains)
- ☐ ☐ ☐ Pharyngitis (sore throat)
- ☐ ☐ ☐ Sinus congestion
- ☐ ☐ ☐ **Cough**
- ☐ ☐ ☐ Productive cough Onset date ___/___/___
- ☐ ☐ ☐ Dry cough Onset date ___/___/___
- ☐ ☐ ☐ Difficulty breathing
- ☐ ☐ ☐ **Dyspnea (shortness of breath)**
- ☐ ☐ ☐ **Pneumonia**
  - Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider Only
  - Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Not tested ☐ Other _____
- ☐ ☐ ☐ **Acute respiratory distress syndrome (ARDS)** Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider only
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Abdominal pain or cramps
- ☐ ☐ ☐ Anosmia (loss of sense of smell)
- ☐ ☐ ☐ Dysgeusia/ageusia (altered, impaired, or lost sense of taste)
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Other symptoms consistent with this disease _____

**First symptom(s) that presented:** ☐ Fever ☐ Chills/rigors ☐ Headache ☐ Myalgia ☐ Pharyngitis ☐ Sinus congestion ☐ Cough ☐ Difficulty breathing ☐ Dyspnea ☐ Pneumonia ☐ ARDS ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Abdominal pain or cramps ☐ Fatigue ☐ Other – Describe: _____

## Pregnancy

**Pregnancy status at time of symptom onset** ☐ Pregnant ☐ Postpartum ☐ Neither pregnant nor postpartum ☐ Unknown

Pregnant at time of SARS-COV-2 Diagnosis? ☐ Yes ☐ No

## Predisposing Conditions

Y N Unk

- ☐ ☐ ☐ Current tobacco smoker
- ☐ ☐ ☐ Smoke or vape
- ☐ ☐ ☐ Diabetes mellitus
- ☐ ☐ ☐ Chemotherapy
- ☐ ☐ ☐ Steroid therapy
- ☐ ☐ ☐ Cancer diagnosis or treatment in 12 months prior to onset Specify _____
- ☐ ☐ ☐ Organ transplant
- ☐ ☐ ☐ Immunosuppressive therapy, condition or disease Specify _____
- ☐ ☐ ☐ Chronic heart disease
- ☐ ☐ ☐ Asthma/reactive airway disease
- ☐ ☐ ☐ Chronic lung disease (e.g., COPD, emphysema)
- ☐ ☐ ☐ Chronic liver disease
- ☐ ☐ ☐ Chronic kidney disease
- ☐ ☐ ☐ Hemoglobinopathy (e.g., sickle cell disease)
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Current prescription or treatment
- ☐ ☐ ☐ Hemodialysis at time of onset
- ☐ ☐ ☐ Other underlying medical conditions Specify _____

**Case Name (last, first)** _____ **WDRS #** _____

## RISK AND RESPONSE SOURCE FOR ILLNESS OF CASE

Is the patient (check all that apply)

- ☐ Health care worker (HCW)
- ☐ US military
- ☐ Flight crew
- ☐ Associated with school
- ☐ Associated with Long-term care facility
- ☐ Associated with Senior living center or Rehab facility
- ☐ Associated with Long-term care/Rehab/Retirement center
- ☐ Associated with a prison
- ☐ Living homeless
- ☐ Immune compromised
- ☐ EMD/First responder
- ☐ Other – Specify _____

**Y N**

☐ ☐ At the time of your COVID-19 test or symptom onset date were you staying in your permanent home

**IF NO:** Where did you sleep the night before your symptom onset date or COVID-19 test

☐ Private residence (alone or with others) for travel/work (e.g., house, condominium, manufactured home, apartment)
☐ Hospital (admission) ☐ Hospital (emergency department) ☐ Cabin or bunkhouse (e.g., staying with other workers)
☐ Tent ☐ Dormitory ☐ Correctional facility (e.g., jail, prison) ☐ Drug rehabilitation facility ☐ Psychiatric facility
☐ Hotel/motel for travel ☐ Hotel/motel as primary residence/shelter
☐ Doubled up with friends/family (temporarily housed with friends/family – but not for travel)
☐ Emergency shelter/homeless shelter ☐ Unsheltered (e.g.,on a street, in a vehicle, or other place not meant for habitation)
☐ Unknown ☐ Other _____

**IF NO:** Does your employer provide your housing? ☐ Yes ☐ No

**Y N Unk**

☐ ☐ ☐ In the fourteen (14) days prior to symptom onset, did the patient have close contact with a confirmed or probable coronavirus case
Contact end date ___/___/___ Contact start date ___/___/___
WDRS Event ID _____ *or if not in WDRS:* Name _____ DOB ___/___/___

☐ ☐ ☐ In the fourteen (14) days prior to symptom onset, did the patient have close contact with a Person Under Investigation (PUI for coronavirus infection)

☐ ☐ ☐ Epi-linked to a confirmed case (make sure to **link** events in WDRS)

☐ ☐ ☐ Contact with person with pneumonia or influenza-like illness

**Suspected exposure setting:**

☐ Daycare/childcare ☐ School (not college) ☐ Doctor's office ☐ Hospital ward ☐ Hospital ER ☐ Hospital outpatient facility
☐ Home ☐ Work ☐ College ☐ Military ☐ Correctional facility ☐ Place of worship ☐ Laboratory ☐ Long term care facility
☐ Homeless/shelter ☐ International travel ☐ Out of state travel ☐ Transit ☐ Social event ☐ Large public gathering
☐ Restaurant ☐ Hotel/motel/hostel ☐ Other - Specify _____

Describe suspected exposure setting (e.g., name of facility, dates)

**Case Name (last, first)** _____ **WDRS #** _____

**Travel – during the 14 days before symptom onset/date tested did you travel?**

| | Setting 1 | Setting 2 | Setting 3 |
|---|---|---|---|
| | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ |
| Travel out of: | ☐ County/City_____<br>☐ State_____<br>☐ Country _____ | ☐ County/City_____<br>☐ State_____<br>☐ Country _____ | ☐ County/City_____<br>☐ State_____<br>☐ Country _____ |
| Travel to: | ☐ County/City_____<br>☐ State_____<br>☐ Country _____ | ☐ County/City_____<br>☐ State_____<br>☐ Country _____ | ☐ County/City_____<br>☐ State_____<br>☐ Country _____ |
| Flight Information | Itinerary #_____<br>Airline Name_____<br>Flight Number_____<br>Seat Number_____ | Itinerary #_____<br>Airline Name_____<br>Flight Number_____<br>Seat Number_____ | Itinerary #_____<br>Airline Name_____<br>Flight Number_____<br>Seat Number_____ |
| Start and end dates | / / to / / | / / to / / | / / to / / |

Likely geographic region of exposure:

- ☐ In Washington state – County: _____
- ☐ US but not Washington state – State: _____
- ☐ Not in US – Country: _____
- ☐ Unable to determine
- ☐ Unknown

**TRANSMISSION AFTER CASE IS SYMPTOMATIC**

☐ Yes ☐ No ☐ Unk **Visited, attended, employed, or volunteered at any public settings (including healthcare) while contagious**

**Settings and details (check all that apply)**

☐ Daycare ☐ School ☐ Airport ☐ Hotel/Motel/Hostel ☐ Transit ☐ Healthcare ☐ Home ☐ Work ☐ College
☐ Military ☐ Correctional facility ☐ Place of worship ☐ International travel ☐ Out of state travel ☐ LTCF
☐ Homeless/shelter ☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Other

| | Setting 1 | Setting 2 | Setting 3 | Setting 4 |
|---|---|---|---|---|
| **Setting Type (as checked above)** | | | | |
| **Facility Name** | | | | |
| **Start Date** | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ |
| **End Date** | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ |
| **Time of arrival** | | | | |
| **Time of departure** | | | | |
| **Number of people potentially exposed** | | | | |
| **List of contacts known?** | ☐ Y ☐ N ☐ Unk | ☐ Y ☐ N ☐ Unk | ☐ Y ☐ N ☐ Unk | ☐ Y ☐ N ☐ Unk |
| **Notes** | | | | |

Contact name: _____
Date of first contact ___/___/___
Date of last contact ___/___/____
County _____
Home phone _____
Work phone _____

Contact name: _____
Date of first contact ___/___/___
Date of last contact ___/___/____
County _____
Home phone _____
Work phone _____

**Case Name (last, first)** _____ **WDRS #** _____

## CLINICAL TESTING

**Y N Unk**

☐ ☐ ☐ COVID-19 testing performed - Date ___/___/___
- ☐ Positive ☐ Pending
- ☐ Negative ☐ Not done
- ☐ Indeterminate ☐ Specimen inadequate

☐ ☐ ☐ Flu testing performed - Date ___/___/___
- ☐ Positive ☐ Pending
- ☐ Negative ☐ Not done
- ☐ Indeterminate ☐ Specimen inadequate

☐ ☐ ☐ Viral respiratory panel - Date ___/___/___
- ☐ Positive ☐ Pending
- ☐ Negative ☐ Not done
- ☐ Indeterminate ☐ Specimen inadequate

## MOLECULAR GENETICS

**Y N**

☐ ☐ Was specimen selected for sequencing?

Date the sample was sent for sequencing ___/___/___
Reason for sequencing _____
Lab performing the sequencing _____
Sequencing status ☐ Complete ☐ Pending ☐ Failed ☐ Not Done
☐ Low Quality ☐ High CT
Sequence repository _____
Sequencing accession number _____
Variant identified _____ (write in variant or "Invalid")
Clinical accession number _____
Specimen collection date ___/___/___
Sequencing Notes

**Y N**

☐ ☐ LHJ Reviewed

## VACCINATION

PLEASE NOTE that when 'Coronavirus' is listed below it is referring specifically to SARS-COV-2

**Y N Unk**

☐ ☐ ☐ Ever received Coronavirus containing vaccine

Number of Coronavirus doses prior to illness _____
Date of first vaccine dose (patient reported) ___/___/___
Date of second vaccine dose (patient reported) ___/___/___

☐ ☐ Vaccine information available

Date of vaccine administration ___/___/___
Vaccine administered (Type) ☐ AstraZeneca ☐ Johnson and Johnson ☐ Moderna ☐ Pfizer (BioNTech)
☐ Other ☐ Unknown

Information source ☐ Washington Immunization Information System (WIIS) ☐ Medical record
☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

Vaccine lot number _____
Administering Provider _____
Administering Provider ID _____
Administering Provider Street _____
Administering Provider Street 2 _____
Administering Provider City _____
Administering Provider State _____
Administering Provider Zip _____

Sources reviewed (check all that apply)
- ☐ Patient immunization record ☐ Parent report
- ☐ Medical records ☐ News/media report
- ☐ Coroner's report ☐ Other _____
- ☐ Immunization information system (registry)

**Case Name (last, first)** _____ **WDRS #** _____

**Second dose**

Date of vaccine administration ___/___/___

Vaccine administered (Type) ☐ AstraZeneca ☐ Johnson and Johnson ☐ Moderna ☐ Pfizer (BioNTech) ☐ Other ☐ Unknown

Information source ☐ Washington Immunization Information System (WIIS) ☐ Medical record ☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

Vaccine lot number _____

Administering Provider _____

Administering Provider ID _____

Administering Provider Street _____

Administering Provider Street 2 _____

Administering Provider City _____

Administering Provider State _____

Administering Provider Zip _____

## HOSPITALIZATION

| Y | N | Unk | |
|---|---|---|---|
| ☐ | ☐ | ☐ | **Hospitalized for this illness** **Facility name** _____ |
| | | | **Hospital admission date** ___/___/___ |
| | | | **Hospital discharge date** ___/___/___ |
| ☐ | ☐ | ☐ | **Admitted to ICU** |
| ☐ | ☐ | ☐ | **Mechanical ventilation or intubation required** |
| ☐ | ☐ | ☐ | **Still hospitalized** |

| Y | N | Unk | |
|---|---|---|---|
| ☐ | ☐ | ☐ | **Died of this illness** Death date ___/___/___ *Please fill in the death date information on the Person Screen* |

## TREATMENT

| Y | N | Unk | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Did patient receive prophylaxis/treatment |

Specify antibiotic _____

Specify antiviral ☐ IG ☐ Acyclovir ☐ Amantadine ☐ Brincidofovir ☐ Cidofovir ☐ Interferon ☐ Oseltamivir ☐ Peramivir ☐ Remdesivir ☐ Ribavirin ☐ Rimantadine ☐ Tecovirimat ☐ Telaprevir ☐ Trifluridine ☐ Vidarabine ☐ Zanamivir ☐ Other - Specify _____

Specify other medication _____

Number of days actually taken _____

Treatment start date ___/___/___

Treatment end date ___/___/___

Prescribed dose _____ ☐ g ☐ mg ☐ ml

Duration _____ ☐ Days ☐ Weeks ☐ Months

Indication ☐ PEP ☐ PrEP ☐ Treatment for disease ☐ Incidental ☐ Other _____

Did patient take medication as prescribed ☐ Yes ☐ No - Why not _____ ☐ Unk

Prescribing provider _____

## NOTES

**Permission received to use case name in conversations with contacts** ☐ Yes ☐ No