Novel Coronavirus

County

Case name (last, first) ______________________________
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 ______________

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 _____________
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 _____________

REPORT SOURCE

Initial report source ______________________________
LHJ ______________________________
Reporter organization ______________________________
Reporter name ______________________________
Reporter phone ______________________________

All reporting sources (list all that apply)
____
____
____

COMMUNICATIONS

Primary HCP name ______________________________
Phone ______________________________
OK to talk to patient (If Later, provide date)
☐ Yes ☐ Later ___/___/___ ☐ Never
Date of interview attempt ___/___/___
☐ Complete ☐ Partial ☐ Unable to reach
☐ Patient could not be interviewed
Alternate contact ☐ Parent/Guardian ☐ Spouse/Partner
☐Friend ☐ Other ______________________
Name ________________ Phone ________________

CLINICAL INFORMATION

Complainant ill ☐ Yes ☐ No ☐ Unk Symptom Onset ___/___/___ ☐ Derived Diagnosis date ___/___/___
Illness duration _______ ☐ Days ☐ Weeks ☐ Months ☐ Years Illness is still ongoing ☐ Yes ☐ No ☐ Unk
Disease suspected ☐ MERS ☐ SARS ☐ Other novel coronavirus ______________________________

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)
☐ ☐ ☐ **Cough**
☐ ☐ ☐ **Productive cough** Onset date ___/___/___
☐ ☐ ☐ Dry cough Onset date ___/___/___
☐ ☐ ☐ Dyspnea (shortness of breath)
☐ ☐ ☐ **Acute respiratory infection with fever and cough**
☐ ☐ ☐ **Pneumonia**
Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider Only
Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Not tested ☐ Other ______________________________

Coronavirus required variables are in **bold.** Answers are: Yes, No, Unknown to case

Case Name ___________________________________ LHJ Case ID ___________________________________

☐ ☐ ☐ **Acute respiratory distress syndrome (ARDS)** Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider only
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Diarrhea *(3 or more loose stools within a 24 hour period)*
☐ ☐ ☐ Abdominal pain or cramps
☐ ☐ ☐ Renal failure
☐ ☐ ☐ Other symptoms consistent with this disease ___________________________________

Predisposing Conditions

Y N Unk
☐ ☐ ☐ Current tobacco smoker
☐ ☐ ☐ Obesity
☐ ☐ ☐ 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)
☐ ☐ ☐ Current prescription or treatment
☐ ☐ ☐ Hemodialysis at time of onset
☐ ☐ ☐ Other underlying medical conditions ___________________________________

Clinical Testing

Y N Unk
☐ ☐ ☐ Coronavirus testing performed

Hospitalization

Y N Unk
☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name ___________________________________
Hospital admission date ___/___/___ Discharge ___/___/___ HRN ______________________
Disposition ☐ Another acute care hospital Facility name ___________________________________
☐ Died in hospital
☐ Long term acute care facility Facility name ___________________________________
☐ Long term care facility Facility name ___________________________________
☐ Non-healthcare (home) ☐ Unk ☐ Other ___________________________________
☐ ☐ ☐ Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
☐ ☐ ☐ Mechanical ventilation or intubation required
☐ ☐ ☐ Still hospitalized As of ___/___/___

Y N Unk
☐ ☐ ☐ Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*
☐ ☐ ☐ Autopsy performed
☐ ☐ ☐ Death certificate lists disease as a cause of death or a significant contributing condition
Location of death ☐ Outside of hospital (e.g., home or in transit to the hospital) ☐ Emergency department (ED)
☐ Inpatient ward ☐ ICU ☐ Other ___________________________________

RISK AND RESPONSE (Ask about exposures 14 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	☐ County/City ________ ☐ State ________ ☐ Country ________ ☐ Other ________	☐ County/City ________ ☐ State ________ ☐ Country ________ ☐ Other ________	☐ County/City ________ ☐ State ________ ☐ Country ________ ☐ Other ________
Destination name			
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Risk and Exposure Information

Y N Unk
☐ ☐ ☐ Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country ______________________________
☐ ☐ ☐ Does the case know anyone sharing travel with similar symptoms of illness
Countries of travel ____________________________
☐ ☐ ☐ In the 14 days prior to symptom onset, did the patient have close contact with a confirmed or probable coronavirus case
Contact start date ___/___/___ Contact end date ___/___/___
Nature of contact (check all that apply) ☐ Same household ☐ Co-worker ☐ Health care environment
☐ Other ___________________________________
☐ ☐ ☐ In the 14 days prior to symptom onset, did the patient have close contact with a Person Under Investigation (PUI) for coronavirus infection

Case Name ______________________ LHJ Case ID ______________________

Y N Unk

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

Is the patient (check all that apply) ☐ Health care worker ☐ US military ☐ Flight crew ☐ Other position of concern ______________

Exposure and Transmission Summary

Likely geographic region of exposure ☐ In Washington – county ________ ☐ Other state ________ ☐ Not in US - country ________ ☐ Unk

International travel related ☐ During entire exposure period ☐ During part of exposure period ☐ No international travel

Suspected exposure type ☐ Foodborne ☐ Animal related ☐ Person to person ☐ Sexual ☐ Health care associated ☐ Unk ☐ Other ______________

Describe ______________

Suspected exposure setting ☐ Day care/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 ☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Hotel/motel/hostel ☐ Other ______________

Describe ______________

Exposure summary

Suspected transmission type ☐ Person to person ☐ Sexual ☐ Blood products ☐ Health care associated ☐ Unk ☐ Other ______________

Describe ______________

Suspected transmission setting ☐ Day care/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 ☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Hotel/motel/hostel ☐ Other ______________

Describe ______________

Public Health Issues

Y N Unk

☐ ☐ ☐ Was the patient symptomatic during travel from any coronavirus affected areas or within 24 hours of return to the US or local area

List all travel on public conveyances from 24 hours before onset of fever or symptoms and thereafter (list each portion or leg of trip)

	Leg 1	Leg 2	Leg 3	Leg 4
Start and end date	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___
Departure and arrival cities	From ________ To ________	From ________ To ________	From ________ To ________	From ________ To ________
Transportation type	☐ Airline ☐ Train ☐ Cruise ☐ Bus ☐ Auto ☐ Tour group ☐ Other ________	☐ Airline ☐ Train ☐ Cruise ☐ Bus ☐ Auto ☐ Tour group ☐ Other ________	☐ Airline ☐ Train ☐ Cruise ☐ Bus ☐ Auto ☐ Tour group ☐ Other ________	☐ Airline ☐ Train ☐ Cruise ☐ Bus ☐ Auto ☐ Tour group ☐ Other ________
Transport company				
Transport number				

If needed, enter detailed information in the Transmission Tracking Question Package

Public Health Interventions/Actions

Y N Unk

☐ ☐ ☐ Isolation precautions

☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___

TRANSMISSION TRACKING

Visited, attended, employed, or volunteered at any public settings while contagious ☐ Yes ☐ No ☐ Unk

Settings and details (check all that apply)

☐ Day care ☐ School ☐ Airport ☐ Hotel/Motel/Hostel ☐ Transit ☐ Health care ☐ 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				

Case Name ________________________________ LHJ Case ID ________________________________

	Setting 1	Setting 2	Setting 3	Setting 4
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
Is a list of contacts known?	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk

If list of contacts is known, please fill out Contact Tracing Form Question Package

TREATMENT

Y N Unk

☐ ☐ ☐ Did patient receive prophylaxis/treatment

Specify medication ________________________ ☐ Antibiotic ☐ Antiviral ☐ Other

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

LAB RESULTS

Lab report information

Lab report reviewed – LHJ ☐

WDRS user-entered lab report note

Submitter ________________________________

Performing lab for entire report ________________________________

Referring lab ________________________________

Specimen

Specimen identifier/accession number ________________________________

Specimen collection date ___/___/___ Specimen received date ___/___/___

WDRS specimen type ________________________________

WDRS specimen source site ________________________________

WDRS specimen reject reason ________________________________

Test performed and result

WDRS test performed ________________________________

WDRS test result, coded ________________________________

WDRS test result, comparator _______

WDRS result, numeric only (enter only if given, including as necessary ***Comparator*** and ***Unit of measure***) _______

WDRS unit of measure _______

Test method ________________________________

WDRS interpretation code ________________________________

Test result – Other, specify ________________________________

WDRS result summary ☐ Positive ☐ Negative ☐ Indeterminate ☐ Equivocal ☐ Test not performed ☐ Pending

Test result status ☐ Final results; Can only be changed with a corrected result
☐ Preliminary results
☐ Record coming over is a correction and thus replaces a final result
☐ Results cannot be obtained for this observation
☐ Specimen in lab; results pending

Result date ___/___/___

Upload document

Ordering Provider

WDRS ordering provider ________________________________

Ordering facility

WDRS ordering facility name ________________________________

APPENDIX A: Novel Coronavirus WORKSHEET

COLLECT THE FOLLOWING INFORMATION FOR EACH DATE:

Locations of potential exposure and transmission
- Addresses and phone numbers of locations
- Dates and times visited (time of arrival and length of stay)
- Complete travel information (e.g., departure & arrival cities, method of transport, transport company, transport numbers)
- Remember to ask about stops at grocery stores, gas stations, churches, healthcare facilities, schools and child care centers

Information about Contacts
- Names and phone numbers of contacts
- Relation to case
- Are contacts symptomatic?

Name: ___________________________________ Patient DOB: ____/_____/_____

PART I: Identifying Sources of Infection

	DATE	DAY	LOCATIONS (with times)	CONTACTS
EARLIEST EXPOSURE DATE		-14		
		-13		
		-12		
		-11		
		-10		
		-9		
		-8		
Exposure Period		-7		
		-6		
		-5		
		-4		
		-3		
		-2		
		-1		
SYMPTOM ONSET		0	See Part B for Contagious Period	

PART II: Identifying Exposed Contacts and Sites of Transmission

	DATE	DAY	LOCATIONS (with times)	CONTACTS
SYMPTOM ONSET		0		
		1		
		2		
		3		
		4		
		5		
Contagious Period		6		
		7		
		8		
		9		
		10		
		11		
		12		
		13		
		14		