



Novel Coronavirus

County _____

Case name (last, first) _____

Birth date ___/___/___ Age at symptom onset _____ Years Months

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 Investigation in progress Not reportable Probable Ruled out Suspect

Investigation status

Complete Complete – not reportable to DOH Unable to complete Reason _____ In progress

Dates: **Investigation start** ___/___/___ Investigation complete ___/___/___ Record complete ___/___/___ **Case complete** ___/___/___

REPORT SOURCE

Initial report source _____ LHJ _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply)

DEMOGRAPHICS

Sex at birth: Female Male Other Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity Hispanic, Latino/a, Latinx Non-Hispanic, Latino/a, Latinx Patient declined to respond Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race Amer Ind/AK Native (**specify:** Amer Ind **and/or** AK Native) Asian Black or African American Native HI/Pacific Islander (**specify:** Native HI **and/or** Pacific Islander) White Patient declined to respond Unk

Additional race information:

- Afghan Afro-Caribbean Arab Asian Indian Bamar/Burman/Burmese Bangladeshi Bhutanese
- Central American Cham Chicano/a or Chicanx Chinese Congolese Cuban Dominican Egyptian
- Eritrean Ethiopian Fijian Filipino First Nations Guamanian or Chamorro Hmong/Mong
- Indigenous-Latino/a or Indigenous-Latinx Indonesian Iranian Iraqi Japanese Jordanian Karen
- Kenyan Khmer/Cambodian Korean Kuwaiti Lao Lebanese Malaysian Marshallese Mestizo
- Mexican/Mexican American Middle Eastern Mien Moroccan Nepalese North African Oromo
- Pakistani Puerto Rican Romanian/Rumanian Russian Samoan Saudi Arabian Somali
- South African South American Syrian Taiwanese Thai Tongan Ugandan Ukrainian
- Vietnamese Yemeni Other: _____

What is your (your child's) preferred language? Check one:

- Amharic Arabic Balochi/Baluchi Burmese Cantonese Chinese (unspecified) Chamorro Chuukese
- Dari English Farsi/Persian Fijian Filipino/Pilipino French German Hindi Hmong Japanese
- Karen Khmer/Cambodian Kinyarwanda Korean Kosraean Lao Mandarin Marshallese Mixteco
- Nepali Oromo Panjabi/Punjabi Pashto Portuguese Romanian/Rumanian Russian Samoan
- Sign languages Somali Spanish/Castilian Swahili/Kiswahili Tagalog Tamil Telugu Thai Tigrinya
- Ukrainian Urdu Vietnamese Other language: _____ Patient declined to respond Unknown

Interpreter needed Yes No Unk

EMPLOYMENT AND SCHOOL

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 _____

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 _____

Outbreak related Yes No LHJ Cluster ID _____ Cluster Name _____

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 _____°F

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 _____

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:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> 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

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	<input type="checkbox"/> Airline <input type="checkbox"/> Train <input type="checkbox"/> Cruise <input type="checkbox"/> Bus <input type="checkbox"/> Auto <input type="checkbox"/> Tour group <input type="checkbox"/> Other	<input type="checkbox"/> Airline <input type="checkbox"/> Train <input type="checkbox"/> Cruise <input type="checkbox"/> Bus <input type="checkbox"/> Auto <input type="checkbox"/> Tour group <input type="checkbox"/> Other	<input type="checkbox"/> Airline <input type="checkbox"/> Train <input type="checkbox"/> Cruise <input type="checkbox"/> Bus <input type="checkbox"/> Auto <input type="checkbox"/> Tour group <input type="checkbox"/> Other	<input type="checkbox"/> Airline <input type="checkbox"/> Train <input type="checkbox"/> Cruise <input type="checkbox"/> Bus <input type="checkbox"/> Auto <input type="checkbox"/> Tour group <input type="checkbox"/> 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				
	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)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 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 PendingTest 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 documentOrdering 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
Contagious Period		0		
		1		
		2		
		3		
		4		
		5		
		6		
		7		
		8		
		9		
		10		
		11		
		12		
		13		
		14		

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