Washington State Department of HEALTH

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 childs) 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

Case Name _____ LHJ Case ID _____

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 _____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 _____

☐	☐	☐	**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 _____

Case Name _____ LHJ Case ID _____

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

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

Case Name _____ LHJ Case ID _____

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				

	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		
		6		
Contagious Period		7		
		8		
		9		
		10		
		11		
		12		
		13		
		14		