Human Infection with Coronavirus Disease 2019 (COVID-19) Surveillance Worksheet

NAME _____ (last) _____ (first) **ADDRESS (Street and No.)** _____ **PHONE** _____ **Hospital Record No.** _____

This information will not be sent to CDC

REPORTING SOURCE TYPE
☐ physician ☐ PH clinic
☐ nurse ☐ laboratory
☐ hospital ☐ other clinic
☐ other source type _____

NAME _____
ADDRESS _____
ZIP CODE _____
PHONE (__ __ __) __ __ __ __ __ __ __

LOCAL SUBJECT ID _____
SUBJECT ADDRESS STATE _____
SUBJECT ADDRESS COUNTY _____
SUBJECT ADDRESS ZIP CODE ___ ___ ___ ___ ___

CASE INFORMATION

NNDSS ID _____ **(Local Record/Case ID)**

Date of Birth __ __ __ __ __ __ __ __ (month day year)

Country of Birth _____

Other Birthplace _____

Ethnic Group H=Hispanic/Latino N=Not Hispanic/Latino O=Other _____ U=Unknown

Country of Usual Residence _____

Race ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐White ☐Not asked ☐ Refused to answer ☐Other_____ ☐ Unknown

Sex M=male F=female U=unknown ☐

Age at Case Investigation _____

Age Unit* ____

Date Reported __ __ __ __ __ __ __ __ (month day year)

Reporting State ____

Earliest Date Reported to State __ __ __ __ __ __ __ __ (month day year)

Date First Reported to PHD __ __ __ __ __ __ __ __ (month day year)

Reporting County _____

Earliest Date Reported to County __ __ __ __ __ __ __ __ (month day year)

National Reporting Jurisdiction _____

CDC 2019-nCOV ID _____

Date First Positive Specimen __ __ __ __ __ __ __ __ (mm/dd/yyyy)

If probable case, reason for case classification:
○ Meets clinical criteria AND epidemiologic evidence with no confirmatory lab testing performed for COVID-19
○ Meets presumptive lab evidence AND either clinical criteria OR epidemiologic evidence
○ Meets vital records criteria with no confirmatory lab testing

Case Investigation Start Date __ __ __ __ __ __ __ __ (month day year)

DGMQID _____
[If Epi-X notification of travelers checked, DGMQID]

CASE CLASS STATUS
☐ Confirmed
☐ Probable ☐ Unknown
☐ Suspected ☐ Not a case

DETECTION METHOD

☐	Autopsy	☐	Laboratory reported	☐	Other method (specify below)
☐	Clinical evaluation	☐	Provider reported	☐	_____
☐	Contact tracing of case patient	☐	Routine physical examination	☐	_____
☐	Epi-X notification of travelers	☐	Routine surveillance	☐	Unknown

HOSPITALIZATION INFORMATION

Illness Onset Date __ __ __ __ __ __ __ __ (month day year)

Illness End Date __ __ __ __ __ __ __ __ (month day year)

Illness Duration ____

Duration Units* ____

Hospitalized? Y=yes N=no U=unknown ☐

Hospital Admission Date __ __ __ __ __ __ __ __ (month day year)

Hospital Discharge Date __ __ __ __ __ __ __ __ (month day year)

Duration of Hospital Stay 0 – 998 ☐☐☐ 999=unknown (days)

Patient admitted to an Intensive Care Unit (ICU)? Y=yes N=no U=unknown ☐

If hospitalized, was a translator/Interpreter required? Y=yes N=no U=unknown ☐

ICU Admission Date __ __ __ __ __ __ __ __ (month day year)

If a translator was required, specify the patient's primary language: ☐☐☐

ICU Discharge Date __ __ __ __ __ __ __ __ (month day year)

Pregnant at time of event? Y=yes N=no U=unknown ☐

If yes, trimester at illness onset: ☐

Number Weeks Gestation ☐☐

Did subject die from illness/complications of illness? Y=yes N=no U=unknown ☐

Date of Death __ __ __ __ __ __ __ __ (month day year)

***UNITS** a=year d=day h=hour min=minute mo=month s=second wk=week UNK=unknown

CLINICAL INFORMATION

INFORMATION SOURCE for CLINICAL DATA ☐ Medical records ☐ Patient interview ☐ Unknown ☐ Other (specify) _____

DATE of DIAGNOSIS __ __ / __ __ / __ __ __ __ (month / day / year)

TESTING REASON ☐ Asymptomatic testing ☐ Contact investigation ☐ Community testing site ☐ Screening ☐ Symptomatic ☐ Other (specify) ☐ Unknown

Symptoms present during course of illness? Y=yes N=no U=unknown ☐ **Did symptom(s) resolve?** Y=yes N=no U=unknown ☐

Did the patient have another diagnosis/etiology for illness? Y=yes N=no U=unknown ☐ (if yes, specify) _____

SIGNS and SYMPTOMS

Y	N	U	[Y=yes]	Y	N	U	[N=no]	Y	N	U	[U=unknown]
			Abdominal pain				Subjective fever				Runny nose
			Chest pain				Fever >100.4F (38C)				Sore throat
			Chills				Headache				Vomiting
			Cough				Nausea				Wheezing
			Diarrhea				New olfactory disorder				Other (specify) _____
			Difficulty breathing				New taste disorder				_____
			Dyspnea				Muscle aches				_____
			Fatigue				Rigors				Unknown

CLINICAL FINDINGS

Y	N	U	NA	[Y=yes; N=no; U=unknown]	Y	N	U	NA	[NA=not applicable]
				Acute respiratory distress syndrome (ARDS)					Other (specify) _____
				Abnormal EKG					Pneumonia
				Abnormal chest x-ray					Unknown

TREATMENT TYPE

Y	N	U	[Y=yes; N=no; U=unknown]	DURATION (days)	Y	N	U		DURATION (days)
			Mechanical ventilation/intubation					Other (specify) _____	
			ECMO					Unknown	

Did patient have underlying medical conditions and/or risk behaviors? Y=yes N=no U=unknown ☐ **Provide response for each below:**

Underlying Conditions or Risk Factors **[Y=yes; N=no; U=unknown]**

	Y	N	U		Y	N	U		Y	N	U		Y	N	U
Autoimmune condition				Current smoker				Hypertension				Psychological/psychiatric‡			
Cardiovascular disease				Diabetes mellitus				Immunosuppressive condition				Severe obesity (BMI ≥40)			
Chronic liver disease				Disability†				Other chronic disease				Substance abuse			
Chronic lung disease				Former smoker				Other (specify) _____				Unknown			
Chronic renal disease				†If disability, type _____				‡If mental condition, type _____							

DEMOGRAPHIC INFORMATION

Tribal affiliation? Y=yes N=no U=unknown ☐ **Tribal Name** ☐☐☐☐☐ **Enrolled Tribe Name** ☐☐☐☐☐

RESIDENCE at ILLNESS ONSET

☐	Acute care inpatient facility	☐	Homeless shelter	☐	Long term care facility	☐	Other (specify) _____
☐	Apartment	☐	Hotel	☐	Mobile home	☐	Outside
☐	Assisted living facility	☐	House/single family	☐	Motel	☐	Rehabilitation facility
☐	Correctional facility	☐	Group home	☐	Nursing home	☐	Unknown

Was case-patient a healthcare personnel (HCP) at time of illness onset? Y=yes N=no U=unknown ☐ **If yes, select from below:**

HCP OCCUPATION TYPE

☐	Environmental services	☐	Nurse
☐	Respiratory therapist	☐	Physician
☐	Other	☐	Unknown

HCP WORKPLACE SETTING

☐	Assisted living facility	☐	Hospital
☐	Long term care facility	☐	Nursing home
☐	Rehabilitation facility	☐	Unknown
☐	Other (specify) _____		

EXPOSURE and IMPORTATION INFORMATION

In the 14 days prior to illness onset, did the patient have any of the following exposures: (check all that apply)

Y	N	U	[Y=yes, N=no, U=unknown]	Y	N	U		Y	N	U	
			Airport/Airplane				Other (specify)				International travel
			Adult congregate living facility				Correctional facility				School/university
			Childcare facility				Domestic travel				
			Community event/mass gathering				Unknown exposures in the 14 days prior to illness onset				
			Animal (confirmed/suspected COVID-19)	Animal Type _____							
			Workplace				Workplace critical infrastructure?	Setting (specify) _____			
			Cruise ship or vessel travel as	Name of ship(s) 1) _____				2) _____			
			Contact with confirmed/probable COVID-19 case: ○ community ○ healthcare associated ○ household ○ other _____ ○ unknown								
			If contact with COVID-19 case, was this person a U.S. case?					Linked Case Number _____			

TRAVEL HISTORY

	Country	Departure Date (mm/dd/yyyy)	Return Date (mm/dd/yyyy)
International Destinations		__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __
		__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __
		__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __
	State	**Departure Date** (mm/dd/yyyy)	**Return Date** (mm/dd/yyyy)
Domestic Destinations		__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __
		__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __
		__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __

CASE DISEASE IMPORTED CODE

	Indigenous		In state, out of jurisdiction		Out of state
	International		Unknown		Yes, imported, but not able to determine source state/country

Imported Country _____ **Imported State** _____ **Imported County** _____ **Imported City** _____

Country of Exposure _____ **State or Province of Exposure** _____

County of Exposure _____ **City of Exposure** _____

Outbreak related? Y=yes N=no U=unknown ☐ **Outbreak Name** **Transmission Mode** _ _ _ _ _ _ _ _

LABORATORY INFORMATION

Test Type	Test Result	Result Units	Test Result Quantitative	Date Specimen Collected (mm dd yyyy)	Specimen Type	Performing Laboratory Specimen ID	Performing Laboratory Type

PERFORMING LABORATORY TYPE

1=CDC lab
2=commercial lab
3=hospital lab
4=other clinical lab
5=public health
6=VPD testing lab
8=other
9=unknown

SPECIMEN TYPE

1	Bacterial isolate	9	CSF	17	NP swab	25	Saliva	33	Swab	41	Vesicle fluid
2	Blood	10	Crust	18	NP washing	26	Scab	34	Swab, skin lesion	42	Viral isolate
3	Body fluid	11	DNA	19	Nucleic acid	27	Serum	35	Swab, nasal sinus	43	Other
4	BAL	12	Dried blood	20	Oral fluid	28	Skin lesion	36	Swab, vesicular	44	Unknown
5	Buccal smear	13	Lesion	21	Oral swab	29	Specimen	37	Swab, internal nose		
6	Buccal swab	14	Macular scraping	22	Plasma	30	Lung (BAL wash)	38	Throat swab		
7	Capillary blood	15	Microbial isolate	23	Respiratory	31	Lavage	39	Tissue		
8	Cataract	16	NP aspirate	24	RNA	32	Stool	40	Urine		

TEST RESULT

P=Positive	E=Indeterminate	PHC401=No significant rise in IgG	OTH=Other (specify)	PLR4366=SARS-CoV-2 variant B.1.1.7 (501Y.V1)
N=Negative	Q=Equivocal	PHC402=Significant rise in IgG		PLR4367=SARS-CoV-2 variant B.1.351 (501Y.V2)
I=Pending	U=Unsatisfactory	PHC126=Vaccine type strain		PLR4368=SARS-CoV-2 variant P.1 (501Y.V3)
X=Not done	UNK=Unknown	PHC127=Wild type strain		PHC2325=Other variant (specify)

VACCINATION HISTORY INFORMATION

Vaccinated (has the case-patient ever received a vaccine against this disease)? Y=yes N=no U=unknown ☐

Number of doses against this disease received prior to illness onset? 0–6 99=unknown ☐☐ (doses)

Date of last vaccine dose against this disease prior to illness onset? __ __ __ __ __ __ __ __ (mm/dd/yyyy)

Was the case-patient vaccinated as recommended by the ACIP? Y=yes N=no U=unknown ☐

Vaccine Type	Vaccination Date (month day year)	Vaccine Manuf	Vaccine Lot No.	National Drug Code	Vaccine Expiration Date (month day year)	Vaccination Record Identifier	Vaccine Event Information Source	Vaccine Dose Number

Vaccine Type

207=COVID-19, mRNA, LNP-S, PF, 100 mcg/0.5 mL dose
208=COVID-19, mRNA, LNP-S, PF, 30 mcg/0.3 mL dose
210=COVID-19, vector-nr, rS-ChAdOx1, PF, 0.5 mL dose
211=COVID-19, Subunit, rS-nanoparticle+Matrix-M1 Adjuvant, PF, 0.5mL dose
212=COVID-19, vector-nr, rS-Ad26, PF, 0.5 mL dose
213=SARS-COV-2 (COVID-19) UNSPECIFIED
OTH=other (specify) **UNK**=unknown

Vaccine Event Information Codes

00=New immunization record **05**=Other registy (historical) **08**=Public agency (historical)
01=Unspecified source **06**=Birth certificate (historical) **OTH**=Other
02=Other provider (historical) **07**=School record (historical) **UNK**=Unknown
PHC1435=Patient/parent recall (historical) **PHC1436**=Patient/parent written record
PHC1936=Immunization Information System **PP**=Primary care provider
184225006=Medical record

Vaccine Manufacturer **ASZ**=Astra Zeneca **JSN**=Janssen **MOD**=Moderna **NVX**=Novavax **PFR**=Pfizer

Reason Not Vaccinated Per ACIP

1=religious exemption
2=medical contraindication
3=philosophical objection
4=lab evidence of previous disease
5=MD diagnosis of previous disease
6=too young
7=parent/patient refusal
8=other _____
9=unknown
10=parent/patient forgot to vaccinate
11=vaccine record incomplete/unavailable
12=parent/patient report of previous disease
13=parent/patient unaware of recommendation
14=missed opportunity
15=foreign visitor
16=immigrant
17=vaccine not available
☐☐

Vaccine History Comments

CASE NOTIFICATION

CONDITION CODE 11065 **Immediate National Notifiable Condition** Y=yes N=no U=unknown ☐

Date of First Verbal Notification to CDC __ __ __ __ __ __ __ __ (month day year)

Date of Electronic Case Notification to CDC __ __ __ __ __ __ __ __ (month day year)

State Case ID _____

Legacy Case ID _____

Date First Electonic Submission __ __ __ __ __ __ __ __ (month day year)

Notification Result Status ○ Final results ○ Correction ○ Cannot obtain

Jurisdiction Code _____

Binational Reporting Criteria __ __ __ __ __ __ __ __

MMWR WEEK ☐☐

MMWR YEAR ☐☐☐☐

Current Occupation *(type of work patient does)* _____

Current Occupation Standardized (NIOCCS code) _____

Current Industry *(type of business/industry in which patient works)* _____

Current Industry Standardized (NIOCCS code) _____

Person Reporting to CDC NAME _____ (first) _____ (last)

Person Reporting to CDC Email _____ @ _____

Person Reporting to CDC Phone Number (__ __ __) __ __ __ __ __ __ __

Comments

CLINICAL CASE DEFINITION[§]

Suspect

- Meets supportive laboratory evidence[¶] with no prior history of being a confirmed or probable case.

Probable

- Meets clinical criteria[#] AND epidemiologic linkage[**] with no confirmatory laboratory testing performed for SARS-C0V-2.
- Meets presumptive[††] laboratory evidence.
- Meets vital records[‡‡] criteria with no confirmatory laboratory testing performed for SARS-CoV2.

Confirmed

- Meets confirmatory[§§] laboratory evidence.

[¶]Detection of specific antibody in serum, plasma, or whole blood

Detection of specific antigen by immunocytochemistry in an autopsy specimen

[For suspect cases (positive serology only), jurisdictions may opt to place them in a registry for other epidemiological analyses or investigate to determine probable or confirmed status.]

[#]In the absence of a more likely diagnosis:

- At least <u>two</u> of the following symptoms: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, nausea or vomiting, diarrhea, fatigue, congestion or runny nose, new olfactory disorder, new taste disorder

OR

- Any <u>one</u> of the following symptoms: cough, shortness of breath, difficulty breathing

OR

- Severe respiratory illness with at least one of the following:
  - Clinical or radiographic evidence of pneumonia
  - Acute respiratory distress syndrome (ARDS).

[**]<u>One</u> or more of the following exposures in the prior 14 days:

- Close contact with a confirmed or probable case of COVID-19 disease;
- Member of a risk cohort as defined by public health authorities during an outbreak.

[Close contact is generally defined as being within 6 feet for at least 15 minutes. However, it depends on the exposure level and setting; for example, in the setting of an aerosol-generating procedure in healthcare settings without proper PPE, this may be defined as any duration. Data are insufficient to precisely define the duration of exposure that constitutes prolonged exposure and thus a close contact.

[††]Detection of SARS CoV-2 by antigen test in a respiratory specimen.

[‡‡]A death certificate that lists COVID-19 disease or SARS-CoV-2 as an underlying cause of death or a significant condition contributing to death.

[§§] Detection of SARS-CoV-2 RNA in a clinical or autopsy specimen using a molecular amplification test

[§]https://cdn.ymaws.com/www.cste.org/resource/resmgr/ps/positionstatement2020/Interim-20-ID-02_COVID-19.pdf