

COVID-19 Case Reporting Form

4 May 2020

Title of the document

##### Unique Case ID / Cluster Number (if applicable):

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| **1. Data Collector Information** |
| Name of data collector |  |
| Data collector Institution |  |
| Data collector telephone number |  |
| Email |  |
| Form completion date (dd/mm/yyyy) |  / /  |

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| **2. Case Classification** |
| □ Confirmed □ Suspected □ Probable |
| Further case classification | □ Primary □ Secondary □ Imported |
| **3. Current Status** |
| □ Alive □ Dead □ Recovered □ Unknown/ Lost to follow-up |
| Date of outcome (dd/mm/yyyy) |  / /  |

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| **4. Interview respondent information (if the persons providing the information is not the patient)** |
| First name |  |
| Surname |  |
| Sex | □ Male □ Female □ Unknown |
| Date of Birth (dd/mm/yyyy) |  / /  |
| Relationship to patient |  |
| Respondent address |  |
| Telephone (mobile) number |  |

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| **5. Patient Identifier Information** |
| First name |  |
| Middle name |  |
| Surname |  |
| Gender | □ Male □ Female □ Unknown |
| Date of Birth (dd/mm/yyyy) |  / /  |
| Age (in years if ≥2 years, in months if <2 years) |  |
| Occupation (specify location/facility) | * Health care worker
* Working with animals

□ Health laboratory worker* Student
* Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| Country of residence |  |
| Residential address |  |
| Telephone (mobile) number |  |
| Email |  |
| National social number/ identifier (if applicable) |  |
| Nationality |  |
| Ethnicity (optional) |  |
| Responsible Health Centre |  |
| Nursery/School/College if appropriate |  |

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| **6a. Patient symptoms from onset of symptoms** |
| Date of first symptom onset (dd/mm/yyyy) |  / / □ Asymptomatic □ Unknown |
| Fever (≥38 °C) or history of fever | □ Yes □ No □ UnknownIf yes, specify maximum temperature: °C |
| **6b. Respiratory symptoms** |
| Sore throat | □ Yes □ No □ Unknown |
| Runny nose | □ Yes □ No □ Unknown |
| Cough | □ Yes □ No □ Unknown |
| Shortness of breath | □ Yes □ No □ Unknown |
| **6c. Other symptoms** |
| Vomiting | □ Yes □ No □ Unknown |
| Nausea | □ Yes □ No □ Unknown |
| Diarrhea | □ Yes □ No □ Unknown |
| Anosmia (loss of smell) | □ Yes □ No □ Unknown |
| Ageusia (loss of taste) | □ Yes □ No □ Unknown |
| Other symptoms (E.g. headache, rash, conjunctivitis, muscle aches, joint ache, loss of appetite, nosebleed, fatigue, seizures, altered consciousness, other) | □ Yes □ No □ UnknownIf yes, specify: |

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| **7. Patient symptoms: Complications** |
| Hospitalization | □ Yes □ No □ Unknown |
| Name of Health Centre/Hospital |  |
| Address of Health Centre/Hospital |  |
| Date of hospital admission |  / / □ Unknown |
| Date of hospital discharge |  / / □ Unknown |
| ICU (Intensive Care Unit) admission | □ Yes □ No □ Unknown |
| Mechanical ventilation required | □ Yes □ No □ Unknown |
| Acute Respiratory Distress Syndrome (ARDS) | □ Yes □ No □ Unknown |
| Pneumonia by chest X-ray | □ Yes □ No □ UnknownIf yes, date started (dd/mm/yyyy) / /  |
| Other complications | □ Yes □ No □ UnknownIf yes, specify: |

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| **8. Patient pre-existing condition(s)** |
| Pregnancy status | * Yes □ No □ Unknown □ Male

If yes, specify trimester:* First □ Second □ Third
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| Other pre-existing condition(s)(E.g. obesity, cancer, diabetes, HIV, heart disease, asthma, chronic lung disease, chronic liver disease, chronic haemotological disorder, chronic kidney disease, chronic neurological impairment/disease, organ or bone marrow recipient, other) | □ Yes □ No □ UnknownIf yes, specify: |

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| **9. Human exposures in the 14 days before symptom onset** |
| Have you travelled within the last 14 days domestically? | □ Yes □ No □ UnknownIf Yes, dates of travel (DD/MM/YYYY): / / to / / Regions visited: Cities visited: |
| Have you travelled within the last 14 days internationally? | □ Yes □ No □ UnknownIf Yes, dates of travel (DD/MM/YYYY): / / to / / Countries visited: |
| In the past 14 days, have you had contact with anyone with suspected or confirmed COVID-19 infection? | □ Yes □ No □ Unknown If Yes, dates of last contact (DD/MM/YYYY): / /  |
| Patient exposed to person with similar illness | □ Yes □ No □ Unknown |
| Location of exposure | * Home
* Hospital
* Workplace
* Tour group
* School
* Unknown
* Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| **10a. Molecular testing methods and results:** |
| **Complete a new line for each specimen collected and each type of test done** |
| **Lab identification number and name** | **Date sample collected (dd/mm/yyyy)** | **Date sample received by lab (dd/mm/yyyy)** | **Type of sample** | **Type of test** | **Result** | **Result date (dd/mm/yyyy)** | **Specimens shipped to other laboratory for confirmation** |
|  |  / /  |  / /  | * Endotracheal aspirate
* Nasal swab
* Nasopharyngeal swab
* Sputum
* Throat swab
* Others, specify:
 | * PCR
* Whole genome sequencing
* Partial genome

sequencing* Other, specify
 | * POSITIVE for

COVID-19* NEGATIVE for

COVID-19* POSITIVE for other pathogens Please specify which pathogens:

\_\_\_\_\_\_\_\_\_\_ |  / /  | * Yes

If yes, specify Date / / If yes, name of the laboratory: * No
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| **10b. Serology testing methods and results:** |
| **Complete a new line for each specimen collected and each type of test done** |
| **Lab identification number** | **Date Sample collected (dd/mm/yyyy)** | **Date Sample Received (dd/mm/yyyy)** | **Type of Sample** | **Type of test** | **Result (COVID-19 antibody titres)** | **Result date (dd/mm/yyyy)** | **Specimens shipped to other laboratory for confirmation** |
|  |  |  | □ Serum | Specify type (ELISA / | □ POSITIVE |  | □ Yes |
|  / /  |  / /  | □ Others,specify: | IFA IgM/ IgG,Neutralization assay, etc.): | If positive, titre:  |  / /  | If yes, specify Date / /  |
|  |  |  |  | □ NEGATIVE |  | If yes, name of the |
|  |  |  |  | □ INCONCLUSIVE |  | laboratory:  |
|  |  |  |  |  |  | □ No |
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*This document has been developed in accordance with global guidance and contextualized to the Pacific context by the Epidemiology and Surveillance Cell of the World Health Organization and The Pacific Community from the COVID-19 Pacific Joint Incident Management Team. *