Red Text = Gen v2 Data Element
Black Text = COVID 19 MMG Data Element

CDC 2019-nCoV ID: 94659-0

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): PID-7

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Human Infection with 2019 Novel Coronavirus Case Report Form

Reporting Jurisdiction	77968-6	Case state/local ID	
Reporting Health Department		CDC 2019-nCoV ID	94659-0
Contact ID[a]	INV1124	NNDSS loc. rec. ID/Case ID[b]	OBR-3

[a]Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case CA102034567 has contacts CA102034567 -01 and CA102034567 -02. [b]For NNDSS reporters, use GenV2 or NETSS patient identifier.

Interviewer Information

Name of Interviewer: Last: 74549-7 First: 74549-7 Telephone: 74548-9 Email: 74547-1

Affiliation/Organization:

Case Classification and Identification

What is the current status of this person? 77990-0
☐ Lab-confirmed case* ☐ Probable case

If probable, select reason for case classification: 95365-3
☐ Meets clinical criteria AND epidemiologic evidence with no confirmatory lab testing*
☐ Meets presumptive lab evidence± AND either clinical criteria OR epidemiologic evidence
☐ Meets vital records criteria with no confirmatory lab testing

*Detection of SARS-CoV-2 RNA in a clinical specimen using a molecular amplification detection test

± Detection of specific antigen in a clinical specimen, OR detection of specific antibody in serum, plasma, or whole blood indicative of a new or recent infection

Under what process was the case first identified? (check all that apply)
☐ Clinical evaluation ☐ Routine surveillance INV159
☐ Contact tracing of case patient ☐ Other, specify: _____
☐ EpiX notification of travelers. If yes, DGMQID: INV1315
☐ Unknown

Report date of case to CDC (MM/DD/YYYY): OBR-7
___/_____/_____

Date of first positive specimen collection (MM/DD/YYYY):
___/_____/_____ ☐ Unknown ☐ N/A 95366-1

Hospitalization, ICU, and Death Information 54588-9

Was the patient hospitalized? 77974-4
☐ Yes ☐ No ☐ Unknown

If hospitalized, was a translator required?
☐ Yes ☐ No ☐ Unknown

If yes, admission date 1 8656-1 (MM/DD/YYYY) discharge date 1 8649-6

If yes, specify which language: DEM142

Was the patient admitted to an intensive care unit (ICU)? 309904001
☐ Yes ☐ No ☐ Unknown

If yes, admission date 1 95367-9 (MM/DD/YYYY) discharge date 1 95368-7

Did the patient die as a result of this illness?
☐ Yes ☐ No 77978-5

If yes, date of death (MM/DD/YYYY): PID-29 ☐ Unknown date

Case Demographics

Date of birth (MM/DD/YYYY): PID-7 /_____
Age: 77998-3 Age units (yr/mo/day): _____
State of re PID-11.4 County of residence: 77983-5
Does this case have any tribal affiliation? 95369-5
Tribe name(s): 95370-3 Enrolled membe 67884-7

Sex: PID-8
☐ Male ☐ Other
☐ Female ☐ Unknown

If female, currently pregnant?
☐ Yes ☐ No 77996-7 h

Ethnicity: PID-22
☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Unknown

Race (check all that apply): PID-10
☐ Black ☐ White ☐ Asian
☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ Unknown ☐ Other, specify: 32624-9

Which would best describe where the patient was staying at the time of illness onset? 75617-1
☐ House/single family home ☐ Hotel/motel ☐ Nursing home/assisted living facility ☐ Rehabilitation facility ☐ Mobile home
☐ Apartment ☐ Long term care facility ☐ Acute care inpatient facility ☐ Correctional facility ☐ Group home
☐ Homeless shelter ☐ Outside, in a car, or other location not meant for human habitation ☐ Other (specify): _____ ☐ Unknown

Healthcare Worker Information 223366009

Is the patient a health care worker in the United States? ☐ Yes ☐ No ☐ Unknown

If yes, what is their occupation (type of job)? INV1316
☐ Physician ☐ Respiratory therapist ☐ Other, specify: _____
☐ Nurse ☐ Environmental services ☐ Unknown

If yes, what is their job setting? 95372-9
☐ Hospital ☐ Rehabilitation facility ☐ Other, specify:_____
☐ Long-term care facility ☐ Nursing home/assisted living facility ☐ Unknown

Exposure Information

In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply): INV1085 / INV1086

☐ Domestic travel (outside state of normal residence). Specify state(s): 82754-3
☐ International travel. Specify country(s): 82764-2
☐ Cruise ship or vessel travel as passenger or crew member. Specify name of ship: TRAVEL53
☐ Workplace 95373-7
If yes, is the workplace critical infrastructure (e.g., healthcare setting, grocery store)?
☐ Yes, specify workplace setting: 95374-5 ☐ No ☐ Unknown
☐ Airport/airplane
☐ Adult congregate living facility (nursing, assisted living, or long-term care facility)
☐ School/university/childcare center
☐ Correctional facility
☐ Community event/mass gathering
☐ Animal with confirmed or suspected COVID-19. Specify animal: 95376-0
☐ Other exposures, specify: _____
☐ Unknown exposures in the 14 days prior to illness onset

☐ Contact with a known COVID-19 case (probable or confirmed)

If the patient had contact with a known COVID-19 case:
What type of contact?
☐ Household contact INV603
☐ Community-associated contact
☐ Healthcare-associated contact (patient, visitor, or healthcare worker)

Was this person a U.S. case? 95375-2
☐ Yes, nCoV ID(s) _____, _____, INV1124
☐ No, this person was an international case and contact occurred abroad
☐ Unknown if U.S. or international case

Is this case part of an outbreak? 77980-1
☐ Yes, specify outbreak name: 77981-9 ☐ No ☐ Unknown

CDC 2019-nCoV ID: _____

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Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ____/_____/_____

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Human Infection with 2019 Novel Coronavirus Case Report Form

Clinical course, symptoms, past medical history, and social history

Collected from (check all that apply): ☐ Patient interview ☐ Medical record review 75521-5

Symptoms present during course of illness:
☐ Symptomatic INV576
☐ Asymptomatic
☐ Unknown

If case was symptomatic:
What was the onset date?
Onset date (MM/DD/YYYY): 11368-8
☐ Unknown symptom onset date

Did the patient's symptoms resolve? 95383-6
Date of symptom resolution (MM/DD/YYYY): 77976-9
☐ No, still symptomatic
☐ Symptoms resolved, unknown date
☐ Unknown if symptoms resolved

Did the patient develop pneumonia? ☐ Yes ☐ No ☐ Unknown 75321-0 / INV1314

Did the patient have acute respiratory distress syndrome? ☐ Yes ☐ No ☐ Unknown 75321-0 / INV1314

Did the patient have an abnormal chest X-ray? ☐ Yes ☐ No ☐ Unknown 75321-0 / INV1314 ne

Did the patient have another diagnosis/etiology for their illness? ☐ Yes ☐ No ☐ Unknown 59455-6 / 81885-6

Did the patient have an abnormal EKG? ☐ Yes ☐ No ☐ Unknown 75321-0 / INV1314

Did the patient receive mechanical ventilation (MV)/intubation? ☐ Yes ☐ No ☐ Unknown
If yes, total days with MV (days) _____ 55753-8 / INV1313 / 67453-1

Did the patient receive ECMO? ☐ Yes ☐ No ☐ Unknown 55753-8 / INV1313

If symptomatic, which of the following did the patient experience during their illness? 56831-1 / INV919

Fever >100.4F (38C)[c]	☐Yes	☐No	☐Unk	Cough (new onset or worsening of chronic cough)	☐Yes	☐No	☐Unk
Subjective fever (felt feverish)	☐Yes	☐No	☐Unk	Wheezing	☐Yes	☐No	☐Unk
Chills	☐Yes	☐No	☐Unk	Shortness of breath (dyspnea)	☐Yes	☐No	☐Unk
Rigors	☐Yes	☐No	☐Unk	Difficulty breathing	☐Yes	☐No	☐Unk
Muscle aches (myalgia)	☐Yes	☐No	☐Unk	Chest pain	☐Yes	☐No	☐Unk
Runny nose (rhinorrhea)	☐Yes	☐No	☐Unk	Nausea or vomiting	☐Yes	☐No	☐Unk
Sore throat	☐Yes	☐No	☐Unk	Abdominal pain	☐Yes	☐No	☐Unk
New olfactory and taste disorder(s)	☐Yes	☐No	☐Unk	Diarrhea (≥3 loose stools/24hr period)	☐Yes	☐No	☐Unk
Headache	☐Yes	☐No	☐Unk	Other, specify: _____, _____, _____	☐Yes	☐No	☐Unk
Fatigue	☐Yes	☐No	☐Unk				

Did they have any underlying medical conditions and/or risk behaviors? ☐Yes ☐No ☐Unknown INV235 INV1117 / INV1118

Diabetes Mellitus	☐Yes	☐No	☐Unk	Immunosuppressive condition	☐Yes	☐No	☐Unk
Hypertension	☐Yes	☐No	☐Unk	Autoimmune condition	☐Yes	☐No	☐Unk
Severe obesity (BMI ≥40)	☐Yes	☐No	☐Unk	Current smoker	☐Yes	☐No	☐Unk
Cardiovascular disease	☐Yes	☐No	☐Unk	Former smoker	☐Yes	☐No	☐Unk
Chronic Renal disease	☐Yes	☐No	☐Unk	Substance abuse or misuse	☐Yes	☐No	☐Unk
Chronic Liver disease	☐Yes	☐No	☐Unk	Disability (neurologic, neurodevelopmental, intellectual, physical, vision or hearing impairment) If yes, specify: 95377-8 _____	☐Yes	☐No	☐Unk
Chronic Lung disease (asthma/emphysema/COPD)	☐Yes	☐No	☐Unk				
Other chronic diseases If yes, specify: _____	☐Yes	☐No	☐Unk				
Other underlying condition or risk behavior, specify: _____	☐Yes	☐No	☐Unk	Psychological/psychiatric condition If yes, specify: 91391-3 _____	☐Yes	☐No	☐Unk

SARS-CoV-2 Testing (approved by FDA or other designated authority)

Test INV290	Pos	Neg	Indet./Inconc.	Pend.	Not Done
Molecular amplification test (RT PCR)	☐	INV291 ☐	☐	☐	☐
Serologic test	☐	☐	☐	☐	☐
Other (specify): _____	☐	☐	☐	☐	☐

Specimens for CoV-19 Testing

Specimen ID
1) LAB202 _____
2) _____
3) _____

Additional Comments or Notes

77999-1