**Revised case report form for Confirmed Novel Coronavirus COVID-19**

**(report to WHO within 48 hours of case identification)**

**Date of reporting to national health authority:** **[\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_]**

Reporting country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Why tested for COVID-19:
□ Contact of a case □ Ill Seeking Healthcare due to suspicion of COVID-19 □ Detected at point of entry □ Repatriation □ Routine respiratory disease surveillance systems (e.g influenza) □ Unknown

 *If none of the above*, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  **Section 1: Patient information**

**Unique Case Identifier (used in country): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Age (years): [\_\_\_][\_\_\_][\_\_\_] if <1 year old, [\_\_\_][\_\_\_] in months or if < 1 month, [\_\_\_][\_\_\_] in days

Sex at birth: □ Male □ Female

Place where the case was diagnosed: Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Admin Level 1 (province): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case usual place of residency: Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2: Clinical Status**

Date of first laboratory confirmation test: [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_]

**Any symptoms\* or signs *at time of specimen collection that resulted in first laboratory confirmation*?**

□ No (i.e., asymptomatic) □ Yes □ Unknown

 *If yes,* date of onset of symptoms: [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_]

**Underlying conditions and** **comorbidity:**

Any underlying conditions? □ No □ Yes □ Unknown

 *If yes,* please check all that apply:

|  |  |
| --- | --- |
| □ Pregnancy (trimester: \_\_\_\_\_\_\_\_\_\_\_\_\_\_) | □ Post-partum (< 6 weeks) |
| □ Cardiovascular disease, including hypertension | □ Immunodeficiency, including HIV |
| □ Diabetes  | □ Renal disease |
| □ Liver disease  | □ Chronic lung disease |
| □ Chronic neurological or neuromuscular disease  | □ Malignancy |

 □ Other(s), please specify:

**Health Status at time of reporting:**

Admission to hospital: □ No □ Yes □ Unknown

First date of admission to hospital: [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_]

*If yes*

Did the case receive care in an intensive care unit (ICU)? □ No □ Yes □ Unknown

Did the case receive ventilation? □ No □ Yes □ Unknown

Did the case receive extracorporeal membrane oxygenation? □ No □ Yes □ Unknown

*Is case in isolation with Infection Control Practice in place* □ No □ Yes □ Unknown

Date of isolation: [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_]

**Section 3: Exposure risk in the 14 days prior to symptom onset (prior to testing if asymptomatic)**

Is case a Health Care Worker (any job in a health care setting): □ No □ Yes □ Unknown

 *If yes*, Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the case **travelled** in the 14 days prior to symptom onset?□ No □ Yes □ Unknown

*If yes*, please specify the places the patient travelled to and date of departure from the places:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Country** | **City** | **Date of Departure from the place** |
|  | Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Has case **visited any health care facility** in the 14 days prior to symptom onset?□ No □ Yes □ Unknown

Has case **had contact with a confirmed case** in the 14 days prior to symptom onset? □ No □ Yes □ Unknown

 *If yes,* please list unique case identifiers of all probable or confirmed cases:

 *If yes,* please explain contact setting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Contact ID** |  **First Date of Contact** |  **Last Date of Contact** |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 5 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Most likely country of exposure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 4: Outcome : complete and re-sent the full form as soon as outcome of disease is known or after 30 days after initial report**

**Date of re-submission of this report: [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_]**

If case was asymptomatic at time of specimen collection resulting in first laboratory confirmation, did the case develop any symptoms or signs *at any time* prior to discharge or death:

□ No (i.e., case remains asymptomatic)

□ Yes, asymptomatic case (as previously reported ) developed symptoms and/or signs of illness

 *If yes,* date of onset of symptoms/signs of illness: [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_]

□ Unknown

**Clinical Course:**

Admission to hospital (may have been previously reported): □ No □ Yes □ Unknown

 *If admitted to hospital:*

First date of admission to hospital: [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_]

Did the case receive care in an intensive care unit (ICU)? □ No □ Yes □ Unknown

Did the case receive ventilation? □ No □ Yes □ Unknown

Did the case receive extracorporeal membrane oxygenation? □ No □ Yes □ Unknown

**Health Outcome:** □ Recovered/Healthy □ Not recovered □ Death □ Unknown: □ Other:

If other, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date of Release* from isolation/hospital or *Date of Death:* [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_]

**If released from hospital /isolation, date of last laboratory test:** [\_D\_][\_D\_]/[\_M][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_]

Results of last test: □ positive □ negative □ Unknown

 **Total number of contacts followed for this case:**  \_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unknown