

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

<b>NAME</b>		<b>ADDRESS (Street and No.)</b>	<b>PHONE</b>	<b>Hospital Record No.</b>
_____		_____	_____	_____
(last) (first)		This information will not be sent to CDC		
<b>REPORTING SOURCE TYPE</b>		<b>NAME</b> _____	<b>LOCAL SUBJECT ID</b> _____	
<input type="checkbox"/> physician <input type="checkbox"/> PH clinic <input type="checkbox"/> nurse <input type="checkbox"/> laboratory <input type="checkbox"/> hospital <input type="checkbox"/> other clinic <input type="checkbox"/> other source type _____		<b>ADDRESS</b> _____	<b>SUBJECT ADDRESS STATE</b> _____	
		<b>ZIP CODE</b> _____	<b>SUBJECT ADDRESS COUNTY</b> _____	
		<b>PHONE</b> (____) _____	<b>SUBJECT ADDRESS ZIP CODE</b> _____	
<b>CASE INFORMATION</b>				
<b>NNDSS ID</b> _____ (Local Record/Case ID)	<b>Date of Birth</b> ____-____-____ month day year	<b>Country of Birth</b> _____	<b>Other Birthplace</b> _____	
<b>Ethnic Group</b> H=Hispanic/Latino N=Not Hispanic/Latino O=Other _____ U=Unknown			<b>Country of Usual Residence</b> _____	
<b>Race</b> <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not asked <input type="checkbox"/> Refused to answer <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown				
<b>Sex</b> M=male F=female U=unknown <input type="checkbox"/>	<b>Age at Case Investigation</b> _____	<b>Age Unit*</b> _____	<b>Date Reported</b> ____-____-____ month day year	
<b>Reporting State</b> _____	<b>Earliest Date Reported to State</b> ____-____-____ month day year	<b>Date First Reported to PHD</b> ____-____-____ month day year		
<b>Reporting County</b> _____	<b>Earliest Date Reported to County</b> ____-____-____ month day year	<b>National Reporting Jurisdiction</b> _____		
<b>CDC 2019-nCoV ID</b> _____	<b>Date First Positive Specimen</b> ____-____-____ (mm/dd/yyyy)	<b>If probable case, reason for case classification:</b>		
<b>Case Investigation Start Date</b> ____-____-____ month day year	<b>CASE CLASS STATUS</b> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Unknown <input type="checkbox"/> Suspected <input type="checkbox"/> Not a case	<input type="radio"/> Meets clinical criteria AND epidemiologic evidence with no confirmatory lab testing performed for COVID-19 <input type="radio"/> Meets presumptive lab evidence AND either clinical criteria OR epidemiologic evidence <input type="radio"/> Meets vital records criteria with no confirmatory lab testing		
<b>DGMQID</b> _____ [If Epi-X notification of travelers checked, DGMQID]				
<b>DETECTION METHOD</b>	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	
<b>HOSPITALIZATION INFORMATION</b>				
<b>Illness Onset Date</b> ____-____-____ month day year	<b>Illness End Date</b> ____-____-____ month day year	<b>Illness Duration</b> _____	<b>Duration Units*</b> _____	
<b>Hospitalized?</b> Y=yes N=no U=unknown <input type="checkbox"/>	<b>Hospital Admission Date</b> ____-____-____ month day year	<b>Hospital Discharge Date</b> ____-____-____ month day year		
<b>Duration of Hospital Stay</b> 0-998 _____ 999=unknown (days)	<b>Patient admitted to an Intensive Care Unit (ICU)?</b> Y=yes N=no U=unknown <input type="checkbox"/>			
<b>If hospitalized, was a translator/Interpreter required?</b> Y=yes N=no U=unknown <input type="checkbox"/>	<b>ICU Admission Date</b> ____-____-____ month day year			
<b>If a translator was required, specify the patient's primary language:</b> _____	<b>ICU Discharge Date</b> ____-____-____ month day year			
<b>Pregnant at time of event?</b> Y=yes N=no U=unknown <input type="checkbox"/>	<b>If yes, trimester at illness onset:</b> _____	<b>Number Weeks Gestation</b> _____		
<b>Did subject die from illness/complications of illness?</b> Y=yes N=no U=unknown <input type="checkbox"/>		<b>Date of Death</b> ____-____-____ month day year		
*UNITS a=year d=day h=hour min=minute mo=month s=second wk=week UNK=unknown				

### CLINICAL INFORMATION

<b>INFORMATION SOURCE for CLINICAL DATA</b>	<input type="checkbox"/> Medical records	<input type="checkbox"/> Patient interview	<input type="checkbox"/> Unknown	<b>DATE of DIAGNOSIS</b>	_____
	<input type="checkbox"/> Other (specify) _____				month    day    year

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

<b>Symptom Onset Date</b> _____	<b>Symptom Resolution Date</b> _____	<b>Secondary Diagnosis?</b> Y=yes N=no U=unknown <input type="checkbox"/> (if yes, specify) _____
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SIGNS and SYMPTOMS	Y	N	U	[Y=yes]	Y	N	U	[N=no]	Y	N	U	[U=unknown]
					Abdominal pain				Subjective fever			
				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)				
					Abnormal EKG					Pneumonia
					Abnormal chest x-ray					Unknown

TREATMENT TYPE	Y	N	U	[Y=yes; N=no; U=unknown]	DURATION (days)	Y	N	U	[Y=yes; N=no; U=unknown]	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	NA		Y	N	U	NA		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	HCP WORKPLACE SETTING	Assisted living facility	Hospital
	Respiratory therapist	Physician		Long term care facility	Nursing home
	Other	Unknown		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)**

<b>Y</b>	<b>N</b>	<b>U</b>	[Y=yes, N=no, U=unknown]	<b>Y</b>	<b>N</b>	<b>U</b>		<b>Y</b>	<b>N</b>	<b>U</b>		
			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: <input type="radio"/> community <input type="radio"/> healthcare associated <input type="radio"/> household <input type="radio"/> other _____ <input type="radio"/> unknown									
			If contact with COVID-19 case, was this person a U.S. case?						Linked Case Number _____			

<b>TRAVEL HISTORY</b>	<b>International Destinations</b>	<b>Country</b>	<b>Departure Date (mm/dd/yyyy)</b>	<b>Return Date (mm/dd/yyyy)</b>
		_____	_____	_____
		_____	_____	_____
	<b>Domestic Destinations</b>	<b>State</b>	<b>Departure Date (mm/dd/yyyy)</b>	<b>Return Date (mm/dd/yyyy)</b>
		_____	_____	_____
		_____	_____	_____

<b>CASE DISEASE IMPORTED CODE</b>	<input type="checkbox"/> Indigenous	<input type="checkbox"/> In state, out of jurisdiction	<input type="checkbox"/> Out of state
	<input type="checkbox"/> International	<input type="checkbox"/> Unknown	<input type="checkbox"/> 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

**TEST RESULT**  
 Q=Equivocal result  
 E=Indeterminate  
 N=Negative  
 NS=No significant rise in IgG  
 X=Not done  
 OTH=Other (specify)  
 I=Pending  
 P=Positive  
 S=significant rise in IgG  
 UNK=Unknown  
 U=Unsatisfactory  
 V=Vaccine type strain  
 W=Wild type strain

<b>SPECIMEN TYPE</b>											
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		
<b>PERFORMING LABORATORY TYPE</b>											
1=CDC lab 2=commercial lab 3=hospital lab 4=other 5=other clinical lab 6=public health lab 7=unknown 8=VPD testing lab											

## 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 <small>month day year</small>	Vaccine Manuf	Vaccine Lot No.	National Drug Code	Vaccine Expiration Date <small>month day year</small>	Vaccination Record Identifier	Vaccine Event Information Source	Vaccine Dose Number

<p><b>Vaccine Type</b></p> <p>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                  213=SARS-COV-2 (COVID-19) UNSPECIFIED                  OTH=other</p>	<p><b>Vaccine Event Information Codes</b></p> <p>00=New immunization record      05=Other registry (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</p>
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**Vaccine Manufacturer**      PFR=Pfizer      MOD=Moderna US

**Reason Not Vaccinated Per ACIP**

1=religious exemption	5=MD diagnosis of previous disease	9=unknown	13=parent/patient unaware of recommendation
2=medical contraindication	6=too young	10=parent/patient forgot to vaccinate	14=missed opportunity
3=philosophical objection	7=parent/patient refusal	11=vaccine record incomplete/unavailable	15=foreign visitor
4=lab evidence of previous disease	8=other _____	12=parent/patient report of previous disease	16=immigrant

**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 Electronic 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** \_\_\_\_\_ (first)      **Person Reporting to CDC Email** \_\_\_\_\_ @ \_\_\_\_\_  
**NAME** \_\_\_\_\_ (last)      **Person Reporting to CDC Phone Number** (\_\_\_\_) \_\_\_\_\_

**Comments**

## CLINICAL CASE DEFINITION<sup>§</sup>

### Suspect

- ♦ Meets supportive laboratory evidence<sup>¶</sup> with no prior history of being a confirmed or probable case.

### Probable

- ♦ Meets clinical criteria<sup>#</sup> AND epidemiologic linkage<sup>\*\*</sup> with no confirmatory laboratory testing performed for SARS-CoV-2.
- ♦ Meets presumptive<sup>††</sup> laboratory evidence.
- ♦ Meets vital records<sup>‡‡</sup> criteria with no confirmatory laboratory testing performed for SARS-CoV2.

### Confirmed

- ♦ Meets confirmatory<sup>§§</sup> laboratory evidence.

<sup>¶</sup>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.]*

<sup>#</sup>In the absence of a more likely diagnosis:

- At least two 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 one 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).

<sup>\*\*</sup>One 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.]*

<sup>††</sup>Detection of SARS CoV-2 by antigen test in a respiratory specimen.

<sup>‡‡</sup>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.

<sup>§§</sup> Detection of SARS-CoV-2 RNA in a clinical or autopsy specimen using a molecular amplification test

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