

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

GENERIC MMG

COVID-19_MMG_V1_0_MMG_F_2020626

NAME _____ (last) (first)	ADDRESS (Street and No.) _____	PHONE _____	Hospital Record No. _____
This information will not be sent to CDC			

REPORTING SOURCE TYPE 48766-0 NAME _____ <input type="checkbox"/> physician <input type="checkbox"/> PH clinic ADDRESS _____ <input type="checkbox"/> nurse <input type="checkbox"/> laboratory ZIP CODE 52831-5 _____ <input type="checkbox"/> hospital <input type="checkbox"/> other clinic PHONE (____) _____ <input type="checkbox"/> other source type _____	LOCAL SUBJECT ID PID-3 _____ SUBJECT ADDRESS STATE PID-11.4 _____ SUBJECT ADDRESS COUNTY PID-11.9 _____ SUBJECT ADDRESS ZIP CODE PID-11.5 _____
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CASE INFORMATION

NNDSS ID OBR-3 (Local Record/Case ID)	Date of Birth _____ PID-7 month day year	Country of Birth 78746-5	Other Birthplace 21842-0
Ethnic Group PID-22 H=Hispanic/Latino N=Not Hispanic/Latino O=Other _____ U=Unknown		Country of Usual Residence 77983-5	
Race PID-10 <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 32624-9 <input type="checkbox"/> Unknown			
Sex M=male F=female U=unknown PID-8	Age at Case Onset 77998-3 Age Unit* _____	Date Reported _____ OBX-6 for 77998-3 77995-9 month day year	
Reporting State 77966-0	Earliest Date Reported to State _____ 77973-6 month day year	Date First Reported to PHD _____ 77968-6 month day year	
Reporting County 77967-8	Earliest Date Reported to County _____ 77972-8 month day year	National Reporting Jurisdiction _____ 77970-2	

CDC 2019-nCoV ID 94659-0	Date First Positive Specimen 95366-1 _____ (mm/dd/yyyy)	If probable case, reason for case classification: 95365-3 <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
Case Investigation Start Date 77979-3 _____ month day year	CASE CLASS STATUS 77990-0 <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Unknown <input type="checkbox"/> Suspected <input type="checkbox"/> Not a case	
DGMQID INV1315 <i>[If Epi-X notification of travelers checked, DGMQID]</i>		

DETECTION METHOD INV159	Autopsy	Laboratory reported	Unknown
	Clinical evaluation	Provider reported	Other (specify below)
	Contact tracing of case patient	Routine physical examination	_____
	Epi-X notification of travelers	Routine surveillance	_____

HOSPITALIZATION INFORMATION

Illness Onset Date _____ 11368-8 month day year	Illness End Date _____ 77976-9 month day year	Illness Duration _____ 77977-7	Duration Units* _____ OBX-6 for 77977-7
Hospitalized? Y=yes N=no U=unknown <input type="checkbox"/>	Hospital Admission Date _____ 8656-1 month day year	Hospital Discharge Date _____ 8649-6 month day year	
Duration of Hospital Stay 0-998 _____ 78033-8 999=unknown (days)	Patient admitted to an Intensive Care Unit (ICU)? Y=yes N=no U=unknown <input type="checkbox"/> 309904001		
If hospitalized, was a translator/Interpreter required? Y=yes N=no U=unknown <input type="checkbox"/> 54588-9	ICU Admission Date _____ 95367-9 month day year		
If a translator was required, specify the patient's primary language: _____ DEM142	ICU Discharge Date _____ 95368-7 month day year		
Pregnant at time of event? Y=yes N=no U=unknown <input type="checkbox"/> 77996-7	If yes, trimester at illness onset: _____ 81271-9	Number Weeks Gestation _____ 81270-1	
Did subject die from illness/complications of illness? 77978-5 Y=yes N=no U=unknown <input type="checkbox"/>			Date of Death _____ PID-29 month day year

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

This annotated worksheet is an NCI draft as of Jan 21, 2021, and is provided as a resource representing the data/structure of the Generic V2 HL7 message mapping guide (Generic_V2_0_MMG_F_R5_20171206) and the COVID-19 HL7 message mapping guide (COVID-19_MMG_V1_0_MMG_F20200626).

CLINICAL INFORMATION

INFORMATION SOURCE for CLINICAL DATA	<input type="checkbox"/> Medical records <input type="checkbox"/> Patient interview <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____	DATE of DIAGNOSIS 77975-1 month day year
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TESTING REASON 67098-4	<input type="checkbox"/> Asymptomatic testing <input type="checkbox"/> Contact investigation <input type="checkbox"/> Community testing site <input type="checkbox"/> Screening <input type="checkbox"/> Symptomatic <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown
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Symptoms present during course of illness? INV576 Y=yes N=no U=unknown **Did symptom(s) resolve?** Y=yes N=no U=unknown 95383-6

Did the patient have another diagnosis/etiology for their illness? 59455-6 Y=yes N=no U=unknown
 (if yes, specify) 81885-6 _____

SIGNS and SYMPTOMS 56831-1	Y	N	U	[Y=yes] INV919	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 75321-0	Y	N	U	NA	[Y=yes; N=no; U=unknown] INV1314	Y	N	U	NA	[NA=not applicable] INV1314
					Acute respiratory distress syndrome (ARDS)					Other (specify) 59455-6 _____
					Abnormal EKG					Pneumonia
				Abnormal chest x-ray					Unknown	

TREATMENT TYPE 55753-8	Y	N	U	[Y=yes; N=no; U=unknown]	DURATION (days)	Y	N	U	INV1313	DURATION (days)	
					Mechanical ventilation/intubation	67453-1				Other (specify) _____	
					ECMO					Unknown	

Did patient have underlying medical condition /or risk behaviors? INV235 Y=yes N=no U=unknown Provide response for each below:

Underlying Conditions or Risk Factors INV1117 [Y=yes; N=no; U=unknown] INV1118																	
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 95377-8 _____						*If mental condition, type 91391-3 _____							

DEMOGRAPHIC INFORMATION

Tribal affiliation? Y=yes N=no U=unknown 95369-5 **Tribal Name** 95370-3 **Enrolled Tribe Name** 67884-7

RESIDENCE at ILLNESS ONSET 75617-1	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 provider (HCP) at time of onset? 223366009 Y=yes N=no U=unknown If yes, select from below:

HCP OCCUPATION TYPE INV1316	Environmental services	Nurse	HCP WORKPLACE SETTING 95372-9	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)**

Y	N	U	[Y=yes, N=no, U=unknown]	<input type="text" value="INV1086"/>	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)				Type animal <input type="text" value="95376-0"/>				
				Workplace				Work <input type="text" value="95373-7"/> critical infrastructure?				Setting (specify) <input type="text" value="95374-5"/>
				Cruise ship or vessel travel as passenger				Name of ship(s) <input type="text" value="TRAVEL53"/> 1) _____ 2) _____				
				Contact <input type="text" value="INV603"/> 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?				<input type="text" value="95375-2"/>				Linked Case Number <input type="text" value="INV1124"/>

TRAVEL HISTORY	International Destinations <input type="text" value="82764-2"/>	Country	Departure Date <input type="text" value="82752-7"/> (mm/dd/yyyy)	Return Date <input type="text" value="TRAVEL08"/> (mm/dd/yyyy)	
			-----	-----	-----
			-----	-----	-----
	Domestic Destinations	State <input type="text" value="82754-3"/>	Departure Date <input type="text" value="82752-7"/> (mm/dd/yyyy)	Return Date <input type="text" value="TRAVEL08"/> (mm/dd/yyyy)	
			-----	-----	
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CASE DISEASE IMPORTED CODE <input type="text" value="77982-7"/>	Indigenous	In state, out of jurisdiction	Out of state
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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	Specimen Type	Performing Laboratory Specimen ID	Performing Laboratory Type
<input type="text" value="INV290"/>	<input type="text" value="INV291"/>	<input type="text" value="LAB115"/>	<input type="text" value="LAB628"/>	<input type="text" value="68963-8"/> mm dd yyyy	<input type="text" value="31208-2"/>	<input type="text" value="LAB202"/>	<input type="text" value="82771-7"/>

TEST RESULT Q=Equivocal result E=Indeterminate N=Negative NS=No IgG significant rise X=Not done OTH=Other (specify) I=Pending P=Positive S=IgG significant rise UNK=Unknown U=Unsatisfactory V=Vaccine type strain W=Wild type strain	SPECIMEN TYPE											
		1	Bacterial isolate	9	CSF	17	NP swab	25	Saliva	33	Swab	41
	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		
PERFORMING LABORATORY TYPE												
	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)? VAC126 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? VAC148 Y=yes N=no U=unknown

Vaccine Type	Vaccination Date	Vaccine Manufacturer	Vaccine Lot No.	National Drug Code	Vaccine Expiration Date	Vaccination Record Identifier	Vaccine Event Information Source	Vaccine Dose Number
30956-7	<input type="text" value="30952-6"/> month day year	<input type="text" value="30957-5"/>	<input type="text" value="30959-1"/>	<input type="text" value="VAC153"/>	<input type="text" value="VAC109"/> month day year	<input type="text" value="VAC102"/>	<input type="text" value="VAC147"/>	<input type="text" value="30973-2"/>

<p>Vaccine Type</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>Vaccine Event Information Codes</p> <p>00=New immunization record 05=Other registry (historical) 08=Public agency (historical) 01=Unspecified source 06=Birth certificate (historical) 0TH=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

Reason Not Vaccinated Per ACIP VAC149

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 <input type="text" value="OBR-31"/>	<input type="text" value="11065"/>	Immediate National Notifiable Condition <input type="checkbox"/> 77965-2 Y=yes N=no U=unknown <input type="checkbox"/>
Date of First Verbal Notification to CDC <input type="text" value="77994-2"/> (month day year)		Date of Electronic Case Notification to CDC <input type="text" value="OBR-22"/> (month day year)
State Case ID <input type="text" value="77993-4"/>	Legacy Case ID <input type="text" value="77997-5"/>	Date First Electronic Submission <input type="text" value="OBR-7"/> (month day year)
Notification Result Status <input type="radio"/> OBR-25 <input type="radio"/> Final results <input type="radio"/> Correction <input type="radio"/> Cannot obtain		Jurisdiction Code <input type="text" value="77969-4"/>
Binational Reporting Criteria <input type="text" value="77988-4"/>	MMWR WEEK <input type="text" value="77991-8"/>	MMWR YEAR <input type="text" value="77992-6"/>
Current Occupation (type of work patient does) <input type="text" value="85658-3"/>		Current Occupation Standardized <input type="text" value="85659-1"/> (NIOCCS code)
Current Industry (type of business/industry in which patient works) <input type="text" value="85078-4"/>		Current Industry Standardized <input type="text" value="85657-5"/> (NIOCCS code)
Person Reporting to CDC NAME <input type="text" value="74549-7"/> (first) <input type="text" value="74549-7"/> (last)		Person Reporting to CDC Email <input type="text" value="74547-1"/> @ _____
		Person Reporting to CDC Phone Number <input type="text" value="74548-9"/> (____) _____
Comments <input type="text" value="77999-1"/>		

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-CoV-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 two of the following symptoms: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, nausea or vomiting, diarrhea, fatigue, congestion or runny nose

OR

- Any one of the following symptoms: cough, shortness of breath, difficulty breathing, new olfactory disorder, new taste disorder

OR

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

^{**}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.]

^{††}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