WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

2019 Novel Coronavirus (COVID-19)
Case Report Form

*Cases of COVID-19 are **immediately reportable** to the local health department (LHD). Providers and LHDs should submit this report to the Division of Infectious Disease Epidemiology by fax at 304-558-8736 for all cases of COVID-19. If you need assistance or specimen testing approval through the WV Office of Laboratory Services, please contact the epidemiologist on call at 304-558-5358, ext. 2.*

Reporting Jurisdiction_____ **Case State/Local ID**_____
Reporting Health Department_____ **CDC 2019-CoV ID** _____
Contact ID_____ **NNDSS loc. rec. ID/Case ID** _____
COVID-19 specimen testing is being conducted through: Private laboratory ☐ State public health laboratory ☐ **State Lab ID** _____

PATIENT INFORMATION

Name: (last, first, middle): _____
Birth date: ____ / ____ / _____ **Age**: _____
Country of birth: _____
Gender: ☐ Male ☐ Female ☐ Unknown
Is the patient deceased? ☐ Yes ☐ No ☐ Unknown If yes, date: __ /__ /____
Address (mailing): _____
Address (physical): _____
City/State/Zip: _____
County: _____
Country: _____
Phone (home): _____ **Phone**(work/cell): _____
Email: _____

Ethnicity: ☐ Not Hispanic or Latino
☐ Hispanic or Latino ☐ Unknown

Race: ☐ White ☐ Black/African American
(Mark all that apply) ☐ Native Hawaiian/Pacific Islander
☐ American Indian/Alaskan Native
☐ Asian ☐ Unknown ☐ Not asked ☐Refused
☐ Other, specify_____

Alternate contact: ☐ Parent/Guardian ☐ Spouse
☐ Other, specify: _____
Name: _____
Phone: _____

INVESTIGATION DETAILS

Investigation start date: __ /__ /____
Investigator name: _____
Telephone: _____
Date of first positive specimen collection __ /__ /_____
Report date of case to CDC __ /__ /_____

What is the current status of this person?
☐ Lab confirmed ☐ Probable ☐ Suspect ☐ Not a case
If probable, select reason for case classification
☐ Meets clinical/epi/No lab conf. ☐ Meets presumptive lab and clinical or epi ☐Meets vital records, no lab confirmation

REPORTING INFORMATION

Date of report: __ /__ /____
Report date to Local Health Department: __ /__ /____
Report date to State Health Department: __ /__ /____

Report Source Type:
☐ Laboratory ☐ Hospital ☐ Private Provider ☐ Public Health Agency
☐ Other _____

Reporting Organization: _____ Phone: _____
Reporting Provider: _____ Phone: _____
Reporting County: _____ Phone: _____

CLINICAL

Patient's Primary Physician: _____ Phone: _____

Was the patient hospitalized for this illness? ☐Yes ☐ No ☐ Unknown
If yes, hospital: _____
If yes, admission date: __ /__ /____
If yes, discharge date: __ /__ /____
Total duration of stay in the hospital (in days) _____
Did the patient die from this illness? ☐Yes ☐ No ☐ Unknown
If yes, date of death: __ /__ /____ ☐ Date unknown

Diagnosis date: __ /__ /____
Illness onset date: __ /__ /____
Illness end date: __ /__ /____
Illness duration: _____ days
Age at onset of illness? _____ years
Is the patient pregnant? ☐Yes ☐ No ☐ Unknown
If yes, due date: __ /__ /____

EPI-LINK & DISEASE ACQUISITION

Is this person associated with a day care facility?
☐ Yes ☐ No ☐ Unknown
Is this person a food handler? ☐ Yes ☐ No ☐ Unknown
Is this case part of an outbreak? ☐ Yes ☐ No ☐ Unknown
If yes, outbreak name? _____
_____

Where was this disease acquired? _____
Imported County: _____
Imported State: _____
Imported City: _____
Imported Country: _____
Country of Usual Residence: _____

CASE STATUS

Transmission Mode: ☐ Airborne ☐ Dermal ☐ Indeterminate ☐ Nosocomial ☐ Bloodborne ☐ Transplacental ☐ Vector borne ☐ Zoonotic
☐ Other, Specify: _____

Detection Mode: ☐ Patient self-referral ☐ Prenatal testing ☐ Prison entry screening ☐ Provider reported ☐ Routine Physical ☐ Unknown
☐ Other, Specify: _____

Case status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unknown
Date CDC was first notified of case: __ /__ /____

PUBLIC HEALTH ACTION DETAILS

Communication #1 Patient contact attempted? ☐ Yes ☐ No ☐Unknown ☐ Not applicable
Patient contact method? ☐ Phone ☐ Letter ☐ Text Message
Date of patient contact: __ /__ /____
Notes:

Communication #2 Patient contact attempted? ☐ Yes ☐ No ☐Unknown ☐ Not applicable
Patient contact method? ☐ Phone ☐ Letter ☐ Text Message
Date of patient contact: __ /__ /____
Notes:

Communication #3 Patient contact attempted? ☐ Yes ☐ No ☐Unknown ☐ Not applicable
Patient contact method? ☐ Phone ☐ Letter ☐ Text Message
Date of patient contact: __ /__ /____
Notes:

Was a certified letter sent to the patient? ☐ Yes ☐ No ☐Unknown ☐ Not applicable Date certified letter was sent: __ /__ /____
Is the patient lost to follow up? ☐ Yes ☐ No ☐Unknown

CLINICAL CARE – INFORMATION SOURCE? ☐ PATIENT INTERVIEW ☐ MEDICAL RECORD REVIEW

Pneumonia? ☐ Yes ☐ No ☐Unknown
Acute respiratory distress? ☐ Yes ☐ No ☐Unknown
Does the patient have another diagnosis/etiology for their illness?
☐ Yes ☐ No ☐Unknown
Chest X-ray confirmed? ☐ Yes ☐ No ☐Unknown
Is the patient symptomatic? ☐ Yes ☐ No ☐ Unknown

If symptomatic, symptom status?
☐ Still symptomatic
☐ Symptoms resolved
☐ Symptoms resolved, unknown date
☐Unknown symptom status
Did the patient have an abnormal EKG? ☐ Yes ☐ No ☐ Unknown

CARE RECEIVED AND ISOLATION

Patient admitted to intensive care unit? ☐ Yes ☐ No ☐ Unknown
If yes, date admitted: __ /__ /____
If yes, discharge date: __ /__ /____
Mechanical ventilation (MV)/intubation required?
☐ Yes ☐ No ☐ Unknown
If yes, total days with MV: _____

Did the patient receive extracorporeal membrane oxygenation (ECMO)? ☐ Yes ☐ No ☐ Unknown
Patient isolated with infection control practices (ICP) in place?
☐ Yes ☐ No ☐ Unknown
Date of isolation: __ /__ /____

SIGNS AND SYMPTOMS

Fever	☐ Yes ☐ No ☐ Unknown Highest temp _____☐F ☐C	Cough	☐ Yes ☐ No ☐ Unknown
Subjective fever	☐ Yes ☐ No ☐ Unknown	Wheezing	☐ Yes ☐ No ☐ Unknown
Chills	☐ Yes ☐ No ☐ Unknown	Dyspnea	☐ Yes ☐ No ☐ Unknown
Rigors	☐ Yes ☐ No ☐ Unknown	Difficulty breathing	☐ Yes ☐ No ☐ Unknown
Myalgia	☐ Yes ☐ No ☐ Unknown	Chest pain	☐ Yes ☐ No ☐ Unknown
Runny nose	☐ Yes ☐ No ☐ Unknown	Nausea	☐ Yes ☐ No ☐ Unknown
Sore throat	☐ Yes ☐ No ☐ Unknown	Vomiting	☐ Yes ☐ No ☐ Unknown
Loss of taste/smell	☐ Yes ☐ No ☐ Unknown	Abdominal pain	☐ Yes ☐ No ☐ Unknown
Headache	☐ Yes ☐ No ☐ Unknown	Diarrhea	☐ Yes ☐ No ☐ Unknown
Fatigue or Malaise	☐ Yes ☐ No ☐ Unknown	Loss of appetite	☐ Yes ☐ No ☐ Unknown

Other symptoms ☐ Yes ☐ No ☐ Unknown
Symptom notes: _____

PRE-EXISTING MEDICAL CONDITIONS? ☐ YES ☐ NO ☐ UNKNOWN				
Diabetes	☐ Yes	☐ No	☐ Unknown	
Hypertension	☐ Yes	☐ No	☐ Unknown	
Obese	☐ Yes	☐ No	☐ Unknown	
Cardiovascular disease	☐ Yes	☐ No	☐ Unknown	
Chronic renal disease	☐ Yes	☐ No	☐ Unknown	
Chronic liver disease	☐ Yes	☐ No	☐ Unknown	
Chronic obstructive pulmonary disease (COPD)	☐ Yes	☐ No	☐ Unknown	
Asthma	☐ Yes	☐ No	☐ Unknown	
Emphysema	☐ Yes	☐ No	☐ Unknown	
Immunocompromised	☐ Yes	☐ No	☐ Unknown	
Autoimmune disease	☐ Yes	☐ No	☐ Unknown	
Other chronic disease	☐ Yes	☐ No	☐ Unknown	(If yes, specify):
Neurologic/neurodevelopmental/intellectual disability	☐ Yes	☐ No	☐ Unknown	(If yes, specify):
Psychological or psychiatric condition	☐ Yes	☐ No	☐ Unknown	(If yes, specify):
Postpartum (<6 weeks)	☐ Yes	☐ No	☐ Unknown	
Malignancy	☐ Yes	☐ No	☐ Unknown	
Smokes tobacco	☐ Yes	☐ No	☐ Unknown	
Former smoker	☐ Yes	☐ No	☐ Unknown	
Substance abuse or misuse	☐ Yes	☐ No	☐ Unknown	

EXPOSURES

Did the patient have contact with a lab confirmed case? (Choose all that apply):

☐ Animal exposure
☐ Community
☐ Exposure to patients with acute lower respiratory distress of unknown etiology
☐ Healthcare patient
☐ Healthcare visitor
☐ Healthcare worker
☐ Healthcare – other, Specify: _____
☐ Household
☐ None ☐Unknown
☐ Other, Specify: _____
_____

Did the patient have contact with a US case? ☐ Yes ☐ No ☐ Unknown If yes, source case nCOV ID? _____

Under what process was the PUI or case first identified? (Choose all that apply):

☐ Clinical evaluation
☐ Contact tracing of case patient
☐ Routine surveillance
☐ EpiX notification of travelers. If yes, DGMQID: _____
☐ Unknown ☐Other, specify: _____

Which would best describe where the patient was staying at the time of onset of illness?

☐ Apartment
☐ Mobile home
☐ Migrant camp
☐ Dorm
☐ Group home
☐ House/condo
☐ Jail
☐ Hotel/motel
☐ Homeless
☐ Prison
☐ Mental health center
☐ Rehab center
☐ Drug treatment center
☐ Juvenile detention center
☐ Drug treatment/detox center
☐ Unknown
☐ Other, please specify: _____
_____
_____

What is the patient's occupation?

☐ Caregiver
☐ Delivery worker
☐ Driver
☐ Electrician
☐ EMT
☐ Engineer
☐ Firefighter
☐ Food preparer/handler
☐ Grocery worker
☐ Healthcare – Dentist
☐ Healthcare – Doctor
☐ Healthcare – Nurse
☐ Healthcare – Ophthalmologist
☐ Healthcare – Surgeon
☐ Housekeeper
☐ Law enforcement
☐ Mechanic
☐ Microbiologist
☐ Miner
☐ National guard
☐ Paramedic
☐ Public health – Epidemiologist
☐ Public health – Laboratorian
☐ Public health – Nurse
☐ Public health – Sanitarian
☐ Pharmacist
☐ Plumber
☐ Politician
☐ Retail Worker
☐ Sanitation worker
☐ Security guard
☐ Student
☐ Teacher
☐ Other, please specify:
_____
_____

What is the setting of the patient's exposure?

☐ Airplane/Public transport	☐ Leisure/Recreational facility	☐ School/College
☐ Community	☐ Long term care facility	☐ Sports facility
☐ Correctional facility	☐ Military	☐ Vacation/Resort
☐ Daycare	☐ Nursing home	☐ Workplace/Office
☐ Grocery store	☐ Prison	☐ Unknown
☐ Home	☐ Restaurant	☐ Other, please specify:
☐ Hospital/Medical facility	☐ Retail store	_____

Is the patient a healthcare worker? ☐ Yes ☐ No ☐ Unknown

If yes, what is their occupation? ☐ Environmental ☐ Nurse ☐ Physician ☐ Respiratory Therapist ☐ Unknown ☐ Other

If yes, what is their job setting? ☐ Hospital ☐ Long term care facility ☐ Nursing home/assisted living facility ☐ Rehabilitation facility ☐ Unknown ☐ Other

Does the patient have a history of being in a healthcare facility in China? ☐ Yes ☐ No ☐ Unknown

TRAVEL

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

Patient had travel exposure(s) in (select all that apply): ☐ China-Mainland ☐France ☐ Germany ☐ Hubei Province ☐ Iran ☐ Italy ☐ None ☐ Other Non-US Country ☐ South Korea ☐ Spain ☐ United Kingdom ☐ Wuhan ☐ Unknown

Did the patient travel domestically? ☐ Yes ☐ No ☐ Unknown If yes, specify: _____

Did the case-patient travel internationally? ☐ Yes ☐ No ☐ Unknown If yes, specify: _____

Air travel exposure? ☐ Yes ☐ No ☐ Unknown

Cruise ship of vessel travel exposure? ☐ Yes ☐ No ☐ Unknown If yes, specify: _____

Attend any large gatherings? ☐ Yes ☐ No ☐ Unknown

Workplace exposure? ☐ Yes ☐ No ☐ Unknown

If yes, is the workplace critical infrastructure? (healthcare setting, grocery store) ☐ Yes ☐ No ☐ Unknown

If yes, specify the workplace setting? _____

Adult congregate living facility? (nursing home, assisted living facility)? ☐ Yes ☐ No ☐ Unknown

School/University/Childcare Center exposure? ☐ Yes ☐ No ☐ Unknown

Correctional facility exposure? ☐ Yes ☐ No ☐ Unknown

Animal exposure? ☐ Yes ☐ No ☐ Unknown If yes, specify: _____

Other exposure? ☐ Yes ☐ No ☐ Unknown If yes, specify: _____

Source of exposure unknown? ☐ Yes ☐ No ☐ Unknown

WAS ADDITIONAL RESPIRATORY TESTING CONDUCTED? ☐ **YES** ☐ **NO** ☐ **UNKNOWN**

Test	Positive	Negative	Pending	Not done
Influenza rapid Ag ☐ A ☐ B	☐	☐	☐	☐
Influenza PCR ☐ A ☐ B	☐	☐	☐	☐
RSV	☐	☐	☐	☐
H. metapneumovirus	☐	☐	☐	☐
Parainfluenza (1-4)	☐	☐	☐	☐
Adenovirus	☐	☐	☐	☐
Rhinovirus/enterovirus	☐	☐	☐	☐
Coronavirus (OC43, 229E, HKU1, NL63)	☐	☐	☐	☐
M. Pneumoniae	☐	☐	☐	☐
C. Pneumoniae	☐	☐	☐	☐
Other, specify:	☐	☐	☐	☐

Was SARS CoV-2 specific antigen (such as rapid testing) detected in a clinical specimen? ☐ Yes ☐ No ☐ Unknown

Did serology testing indicate a new or recent infection? ☐ Yes ☐ No ☐ Unknown

SPECIMENS FOR COVID-19 TESTING

COVID-19 specimen testing is being conducted through:

Private laboratory ☐ Name of Laboratory _____

State public health laboratory (West Virginia Office of Laboratory Services) ☐ ***(Prior approval required)***

Test	Specimen ID	Date Collected	State Lab Tested	State Lab Result
NP Swab		__/__/____	☐	
OP Swab		__/__/____	☐	
Sputum		__/__/____	☐	
Other Specify: _____		__/__/____	☐	

Additional State/Local Specimen IDs: _____ _____ _____ _____ _____

PATIENT CONTACTS

Information as of date: __/__/____ Contact record ID: _____

Comments: _____

_____

_____

Name: (last, first, middle): _____

Birth date: ____/ ____/ _____ **Age**: _____

Gender: ☐ Male ☐ Female ☐ Unknown

Patient deceased? ☐ Yes ☐ No ☐ Unknown If yes, date: __/__/____

Primary Occupation: _____

Country of birth: _____

Address (mailing): _____

Address (physical): _____

City/State/Zip: _____

County: _____

Country: _____

Phone (home): _____ **Phone**(work/cell): _____

Email: _____

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown

Race: ☐ White ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Asian ☐ Unknown ☐ Not asked ☐Refused ☐ Other, specify_____

Disposition:

☐ Confirmed case ☐ Probable case ☐ Suspect case

☐ Insufficient information to begin investigation

☐ Not a contact ☐ Queue for follow up ☐ Not infected

☐ Transferred ☐ Refused evaluation ☐ Patient died

☐ Unable to locate ☐ Lost to follow up ☐Other

Relationship? _____

Exposure type? ☐ Birth ☐Common conveyance ☐Common space ☐ Common substance ☐ Daycare ☐Healthcare, no patient care ☐Healthcare, patient care ☐Hospital patient ☐Hospital visitor ☐Household ☐Inmate ☐Intimate ☐Long-term care facility ☐Needle sharing ☐School ☐Social/recreational ☐Work ☐Unknown ☐Other

Symptoms? ☐ Yes ☐ No ☐ Unknown

If yes, Onset date? __/__/____

Testing completed? ☐ Yes ☐ No ☐ Unknown

If yes, date? __/__/____

Results? ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown

Notes: _____

_____

_____

PATIENT CONTACTS

Information as of date: __ /__ /____ Contact record ID: _____
Comments: _____
_____
_____
Name: (last, first, middle): _____
Birth date: ____ / ____ / _____ **Age**: _____
Gender: ☐ Male ☐ Female ☐ Unknown
Patient deceased? ☐ Yes ☐ No ☐ Unknown If yes, date: __ /__ /____
Primary Occupation: _____
Country of birth: _____
Address (mailing): _____
Address (physical): _____
City/State/Zip: _____
County: _____
Country: _____
Phone (home): _____ **Phone**(work/cell): _____
Email: _____
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown
Race: ☐ White ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Asian ☐ Unknown ☐ Not asked ☐Refused ☐ Other, specify_____

Disposition:
☐ Confirmed case ☐ Probable case ☐ Suspect case
☐ Insufficient information to begin investigation
☐ Not a contact ☐ Queue for follow up ☐ Not infected
☐ Transferred ☐ Refused evaluation ☐ Patient died
☐ Unable to locate ☐ Lost to follow up ☐Other
Relationship? _____
Exposure type? ☐ Birth ☐Common conveyance
☐Common space ☐ Common substance ☐ Daycare
☐Healthcare, no patient care ☐Healthcare, patient care
☐Hospital patient ☐Hospital visitor ☐Household ☐Inmate
☐Intimate ☐Long-term care facility
☐Needle sharing ☐School ☐Social/recreational ☐Work
☐Unknown ☐Other
Symptoms? ☐ Yes ☐ No ☐ Unknown
If yes, Onset date? __ /__ /____
Testing completed? ☐ Yes ☐ No ☐ Unknown
If yes, date? __ /__ /____
Results? ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown

Notes: _____
_____
_____

PATIENT CONTACTS

Information as of date: __ /__ /____ Contact record ID: _____
Comments: _____
_____
_____
Name: (last, first, middle): _____
Birth date: ____ / ____ / _____ **Age**: _____
Gender: ☐ Male ☐ Female ☐ Unknown
Patient deceased? ☐ Yes ☐ No ☐ Unknown If yes, date: __ /__ /____
Primary Occupation: _____
Country of birth: _____
Address (mailing): _____
Address (physical): _____
City/State/Zip: _____
County: _____
Country: _____
Phone (home): _____ **Phone**(work/cell): _____
Email: _____
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown
Race: ☐ White ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Asian ☐ Unknown ☐ Not asked ☐Refused ☐ Other, specify_____

Disposition:
☐ Confirmed case ☐ Probable case ☐ Suspect case
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☐Intimate ☐Long-term care facility
☐Needle sharing ☐School ☐Social/recreational ☐Work
☐Unknown ☐Other
Symptoms? ☐ Yes ☐ No ☐ Unknown
If yes, Onset date? __ /__ /____
Testing completed? ☐ Yes ☐ No ☐ Unknown
If yes, date? __ /__ /____
Results? ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown

Notes: _____
_____
_____

PATIENT CONTACTS

Information as of date: __ /__ /____ Contact record ID: _____
Comments: _____
_____
_____
Name: (last, first, middle): _____
Birth date: ____ / ____ / _____ **Age**: _____
Gender: ☐ Male ☐ Female ☐ Unknown
Patient deceased? ☐ Yes ☐ No ☐ Unknown If yes, date: __ /__ /____
Primary Occupation: _____
Country of birth: _____
Address (mailing): _____
Address (physical): _____
City/State/Zip: _____
County: _____
Country: _____
Phone (home): _____ **Phone**(work/cell): _____
Email: _____
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown
Race: ☐ White ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Asian ☐ Unknown ☐ Not asked ☐Refused ☐ Other, specify_____

Disposition:
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☐Intimate ☐Long-term care facility
☐Needle sharing ☐School ☐Social/recreational ☐Work
☐Unknown ☐Other
Symptoms? ☐ Yes ☐ No ☐ Unknown
If yes, Onset date? __ /__ /____
Testing completed? ☐ Yes ☐ No ☐ Unknown
If yes, date? __ /__ /____
Results? ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown

Notes: _____
_____
_____

PATIENT CONTACTS

Information as of date: __ /__ /____ Contact record ID: _____
Comments: _____
_____
_____
Name: (last, first, middle): _____
Birth date: ____ / ____ / _____ **Age**: _____
Gender: ☐ Male ☐ Female ☐ Unknown
Patient deceased? ☐ Yes ☐ No ☐ Unknown If yes, date: __ /__ /____
Primary Occupation: _____
Country of birth: _____
Address (mailing): _____
Address (physical): _____
City/State/Zip: _____
County: _____
Country: _____
Phone (home): _____ **Phone**(work/cell): _____
Email: _____
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown
Race: ☐ White ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Asian ☐ Unknown ☐ Not asked ☐Refused ☐ Other, specify_____

Disposition:
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☐Needle sharing ☐School ☐Social/recreational ☐Work
☐Unknown ☐Other
Symptoms? ☐ Yes ☐ No ☐ Unknown
If yes, Onset date? __ /__ /____
Testing completed? ☐ Yes ☐ No ☐ Unknown
If yes, date? __ /__ /____
Results? ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown

Notes: _____
_____
_____