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

Human Infection with 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form

*PUIs and Cases of COVID-19 are **immediately reportable** to the Local health department. Providers and Local health departments should submit this report to the Division of Infectious Disease Epidemiology by fax at 304-558-8736. If you need assistance or specimen approval, please contact the epidemiologist on call at 304-558-5358 ext. 1.*

Reporting jurisdiction_____ **Reporting health department**_____
State case ID (PUI ID) _____ **NNDSS loc. rec. ID/Case ID** _____ **Contact ID**_____
Example – The format for the WV PUI ID is WV2020MMDDYY. (WV2020 followed by patient's date of birth (MM/DD/YY).
COVID-19 specimen testing is being conducted through: Private laboratory ☐ State public health laboratory ***(Prior approval required)*** ☐

PATIENT DEMOGRAPHICS

Name: (last, first, middle): _____
Address (mailing): _____
Address (physical): _____
City/State/Zip: _____
County of Residence: _____
Phone (home): _____ **Phone**(work/cell): _____
Email: _____
Alternate contact: ☐ Parent/Guardian ☐ Spouse ☐ Other
Name: _____ Phone: _____

Birth date: ____ / ____ / _____ **Age**: _____
Sex: ☐ Male ☐ Female ☐ Unknown ☐ Other

Residency:
☐ US resident
☐ Non-US resident, country_____

Ethnicity: ☐ Not Hispanic or Latino
☐ Hispanic or Latino ☐ Not specified

Race: (Mark all that apply)
☐ White ☐ Black/African American
☐ Native Hawaiian/ Pacific Islander
☐ American Indian/Alaskan Native
☐ Asian ☐ Unknown ☐ Other, specify_____

INTERVIEWER INFORMATION

Investigation Start Date: __ /__ /____ **Interviewer name: _____** **Telephone: _____**
Affiliation/Organization:_____ **Email: _____**

REPORT SOURCE/HEALTH CARE PROVIDER (HCP)

Report Source: ☐ Laboratory ☐ Hospital ☐ Private Provider ☐ Public Health Agency ☐ Other – Specify _____
Reporter Name: _____ Reporter Phone: _____
Primary HCP Name: _____ Primary HCP Phone: _____
Report date to the Local health dept. (MM/DD/YYYY): __ /__ /____ **Report date to State health dept. (MM/DD/YYYY): __ /__ /____**
Report date of PUI to CDC (MM/DD/YYYY): __ /__ /____ **Report date of case to CDC (MM/DD/YYYY):__ /__ /____**

PATIENT INFORMATION – CASE STATUS AND SYMPTOMS

What is the current status of this person?
☐ PUI, testing pending
☐ PUI, tested negative
☐ Laboratory-confirmed case

Symptoms present during course of illness:
☐ Symptomatic ☐ Asymptomatic ☐ Unknown
If symptomatic, onset date (MM/DD/YYYY): __ /__ /____ ☐ Unknown

If symptomatic, date of symptom resolution (MM/DD/YYYY): **__ /__ /____**
☐ Still symptomatic ☐ Unknown symptom status
☐ Symptoms resolved, unknown date

PATIENT INFORMATION - CLINICAL

Date of first positive specimen collection (MM/DD/YYYY):
__ /__ /____ ☐ Unknown ☐ N/A
Did the patient develop pneumonia?
☐Yes ☐ No ☐ Unknown
Did the patient have acute respiratory distress syndrome?
☐Yes ☐ No ☐ Unknown
Did the patient have another diagnosis/etiology for their illness?
☐Yes ☐ No ☐ Unknown
Did the patient have an abnormal chest X-ray?
☐Yes ☐ No ☐ Unknown

Was the patient hospitalized: ☐Yes ☐ No ☐ Unknown
If yes, admission date 1: (MM/DD/YYYY): __ /__ /____
If yes, discharge date 1: (MM/DD/YYYY): __ /__ /____
Was the patient admitted to an intensive care unit (ICU)?
☐Yes ☐ No ☐ Unknown
Did the patient receive mechanical ventilation (MV)/intubation?
☐Yes ☐ No ☐ Unknown
If yes, total days with MV (days): _____
Did the patient receive ECMO? ☐Yes ☐ No ☐ Unknown
Did the patient die as a result of this illness? ☐Yes ☐ No ☐ Unknown
Date of death (**MM/DD/YYYY): __ /__ /____**☐ Unknown date of death

PATIENT INFORMATION - EPIDEMIOLOGIC

Is the patient a health care worker in the United States? ☐Yes ☐ No ☐ Unknown
Does the patient have a history of being in a healthcare facility (as a patient, worker or visitor) in China? ☐Yes ☐ No ☐ Unknown

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

☐ Travel to Wuhan
☐ Travel to Hubei
☐ Travel to mainland China
☐ Travel to other non-US country
Specify: _____
☐ Household contact with another lab-confirmed COVID-19 case-patient
If the patient had contact with another COVID-19 case, was this person a U.S. case?
☐ Yes, nCoV ID of source case: _____ ☐ No ☐ Unknown ☐ N/A
☐ Community contact with another lab-confirmed COVID-19 case-patient
☐ Any healthcare contact with another lab-confirmed COVID-19 case-patient
If yes, ☐ Patient ☐ Visitor ☐Health care worker ☐ Animal exposure
☐ Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology
☐ Unknown ☐ Other, specify _____

Under what process was the PUI or first case identified? (check all that apply): ☐ Clinical evaluation leading to PUI determination
☐ Contact tracing of case patient ☐ Routine surveillance ☐ Epi-X notification of travelers; if checked, DGMQID _____
☐ Unknown ☐ Other, specify: _____

SYMPTOMS, CLINICAL COURSE, PAST MEDICAL HISTORY AND SOCIAL HISTORY

COLLECTED FROM (CHECK ALL THAT APPLY): ☐ PATIENT INTERVIEW ☐ MEDICAL RECORD REVIEW

During this illness, did the patient experience any of the following symptoms?	Symptom Present?		
Fever >100.4F (38C)[C]	☐ Yes	☐ No	☐ Unknown
Subjective fever (felt feverish)	☐ Yes	☐ No	☐ Unknown
Chills	☐ Yes	☐ No	☐ Unknown
Muscle aches (myalgia)	☐ Yes	☐ No	☐ Unknown
Runny nose (rhinorrhea)	☐ Yes	☐ No	☐ Unknown
Sore throat	☐ Yes	☐ No	☐ Unknown
Cough (new onset or worsening of chronic cough)	☐ Yes	☐ No	☐ Unknown
Shortness of breath (dyspnea)	☐ Yes	☐ No	☐ Unknown
Nausea or vomiting	☐ Yes	☐ No	☐ Unknown
Headache	☐ Yes	☐ No	☐ Unknown
Abdominal pain	☐ Yes	☐ No	☐ Unknown
Diarrhea (≥3 loose/looser than normal stools/24hr period)	☐ Yes	☐ No	☐ Unknown
Other, specify: _____			

PRE-EXISTING MEDICAL CONDITIONS? ☐ Yes ☐ No ☐ Unknown

Chronic Lung Disease (asthma/emphysema/COPD)	☐Yes	☐ No	☐ Unknown	
Diabetes Mellitus	☐Yes	☐ No	☐ Unknown	
Cardiovascular disease	☐Yes	☐ No	☐ Unknown	
Chronic Renal disease	☐Yes	☐ No	☐ Unknown	
Chronic Liver disease	☐Yes	☐ No	☐ Unknown	
Immunocompromised Condition	☐Yes	☐ No	☐ Unknown	
Neurologic/neurodevelopmental/intellectual disability	☐Yes	☐ No	☐ Unknown	(If YES, specify) _____
Other chronic diseases	☐Yes	☐ No	☐ Unknown	(If YES, specify) _____
If female, currently pregnant	☐Yes	☐ No	☐ Unknown	(If YES, due date __ /__ /____)
Current smoker	☐Yes	☐ No	☐ Unknown	
Former smoker	☐Yes	☐ No	☐ Unknown	
Other _____	☐Yes	☐ No	☐ Unknown	
Other _____	☐Yes	☐ No	☐ Unknown	

RESPIRATORY DIAGNOSTIC TESTING

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: _____	☐	☐	☐	☐

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: _____ _____ _____ _____ _____