**Interim Local Health Departments Novel Coronavirus (NCV) Investigation Short Form**

**Please Redact Patient/Parent/Guardian Name and Phone Number before sending to CDC.**

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| --- | --- |
| **Patient’s or Parent/Guardian name (for minors):** | **Patient’s phone:** |

1. For NCV patients under investigation (PUI),fill out the form below and send to [eocreport@cdc.gov](mailto:eocreport@cdc.gov) (subject line: NCV Patient Form) or fax to 770-488-7107. If information is incomplete, please send any information you have as soon as possible then send an updated form when you obtain more information.

Case Definition: see [Interim Guidance for State & Local Health Departments](http://www.cdc.gov/coronavirus/ncv/guidance.html).

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Unique ID** *(CountyName\_###, e.g. Clark\_001)***:** | | | | | | **Reporting county:** | | |
| **Patient’s county of residence:** | | | **State:** | | **Residency:**  **US resident**   **non US resident**  **If non US resident, nationality:** | | | |
| **Interviewer’s name:** | | | | **Phone:** | | | | **Email:** |
| **Date of report:** | **New report Update to previous report** | | | | | | | |
| **1. Age (years): Age in months If aged less than 1 year:**  **2. Sex:**   **3. Date of illness onset:** | | | | | | | | |
| **4. Describe Symptoms:**  Fever  Runny Nose  Sneezing  Cough  Sore Throat  Shortness of Breath  Other symptoms: | | | | | | | | |
| **5. Did patient travel to Middle East in the 10 days prior to illness onset?**  Yes  No  Unknown  **If yes, which countries?**  Depart Date Return Date Location  1)  2) | | | | | **6. Did patient have contact with someone else who traveled to the Middle East in the 10 days prior to illness onset?**  Yes  No Unknown  **If yes, what is relation?**  **Which countries?**  Depart Date Return Date Location  1)  2) | | | |
| **7. In the 10 days before onset did the patient have close contact with any of the following:**  Cows  Bats  Goats  Camels  Sheep  Other animals  If other, what animals? | | | | | **8. Does patient work as a health care worker?**  Yes  No  Unknown  If Yes, name and city of facility: | | | |
| **9. Diagnosis of pneumonia?**  Yes  No  Unknown  If Yes:  Clinical  Radiographic  Other  If other: | | | | | **10. Was the patient hospitalized for this illness?**  Yes  No  Unknown  Hospitalization Date: Discharge Date:  If Yes, hospital name & city: | | | |
| **11. Admitted to ICU**  Yes  No  Unknown  **ICU Start Date:**  **ICU Discharge Date:** | | **12. Mechanical Ventilation**  Yes  No  Unknown  **If known, Start Date:**  **Duration (days):** | | | | | **13. Acute Respiratory Distress Syndrome**  Yes  No  Unknown **Date:** | |
| **14. Renal failure**  Yes  No  Unknown | |
| **15. Fatality**  Yes  No  Unknown | |
| **16. Did patient have any tests performed for respiratory viruses/bacteria?**  Yes  No  Unknown  **Specimen Type: Type of test:** **Date of test:** **Result of test:**  **Specimen Type: Type of test:**  **Date of test:** **Result of test:**  **Specimen Type: Type of test:** **Date of test:** **Result of test:**  **Specimen Type: Type of test:** **Date of test:** **Result of test:**  **17. Is a specimen being sent to CDC for testing?**  Yes  No  UnknownIf Yes, ID#: | | | | | | | | |
| **18. Did patient have contact with a person with ARI in the 10 days prior to illness onset?**  Yes  No  Unknown  **If yes, describe** *(e.g., Case is sibling of a confirmed case)* | | | | | | | | |

2. If patient is later determined to be confirmed, please notify CDC and request the CDC “Novel Coronavirus Confirmed Patient Report Form.”

Thank you for your participation. For questions or concerns, please contact CDC at 770-488-7100 or [eocreport@cdc.gov](mailto:eocreport@cdc.gov).

**CDCNCVID (CDC Use Only):**