**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 (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 BreathOther 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 Location1) 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 Location1) 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 [ ]  UnknownIf Yes, name and city of facility:  |
| **9. Diagnosis of pneumonia?** [ ]  Yes [ ]  No [ ]  UnknownIf 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.

**CDCNCVID (CDC Use Only):**