Cuyahoga County Board of Health

Cluster ID:_____

COVID-19 Tracking Form v.2

Name:_____ DOB: _____

Gender: M F Non-binary Unknown

If minor, parent/guardian(s) name: _____

Address: _____

City: _____ Zip code: _____

Phone: _____ Text OK: Y N

Phone: _____ Text OK: Y N Email: _____

Informant Information (if not patient)

Informant 1:_____

Phone: _____ Additional Information: _____

Informant 2:_____

Phone: _____ Additional Information: _____

ISOLATION *Isolation until d/c criteria met (check CDC guidance)*	☐ **Lab confirmed positive** Date: _____ ODRS #_____ ☐ **Presumptive Positive** Symptom Onset Date: _____ Case Name: _____ Related ODRS Case # (if applicable): _____	☐ **CDC & ODH PUI Form** ☐ **Isolation Letter/packet** Date sent: _____ Initials: ____ ☐ **D/C Isolation** Date: _____ ☐ **Letter** Date sent: _____ Initials: _____
QUARANTINE *14 days from last contact or entry to country without symptoms* **Start: _____** **End: _____**	☐ **Traveler** Return date: _____ ☐ **Case contact** (confirmed/presumptive) Exposure date: _____ Case Name: _____ Related ODRS Case # (if applicable): _____	☐ **No contact (3 attempts doc.)** ☐ **CDC PUI Form** ☐ **Quarantine Letter/packet** Date sent: _____ Initials: _____

☐ Healthcare worker

Facility_____

Date last worked_____

Facility notified? y / n / unknown

☐ Institutionalized

Facility type: LTC SNF Group home Correctional Other

Facility name:_____

Special concerns (e.g. Resource needs identified, facility where hospitalized if applicable)

_____

_____

_____

Response Team

Name	Credentials	Signature	Initials

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC ……

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ____/_____/_____

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC ……

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

Reporting jurisdiction: _____ Case state/local ID: _____
Reporting health department: _____ CDC 2019-nCoV ID: _____
Contact ID [a]: _____ NNDSS loc. rec. ID/Case ID [b]: _____

a. Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case CA102034567 has contacts CA102034567 -01 and CA102034567 -02. [b]For NNDSS reporters, use GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Last _____ First _____
Affiliation/Organization: _____ Telephone _____ Email _____

Basic information

What is the current status of this person?
☐ Patient under investigation (PUI)
☐ Laboratory-confirmed case

Report date of PUI to CDC (MM/DD/YYYY):
____/_____/_____

Report date of case to CDC (MM/DD/YYYY):
____/_____/_____

County of residence: _____
State of residence: _____

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/ Latino
☐ Not specified

Sex:
☐ Male
☐ Female
☐ Unknown
☐ Other

Race (check all that apply):
☐ Asian
☐ Black
☐ White
☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ Unknown
☐ Other, specify: _____

Date of birth (MM/DD/YYYY): ____/_____/_____
Age: _____
Age units(yr/mo/day): _____

Date of first positive specimen collection (MM/DD/YYYY):
____/_____/_____
☐ Unknown ☐ N/A

Did the patient develop pneumonia?
☐ Yes ☐ Unknown
☐ No

Did the patient have acute respiratory distress syndrome?
☐ Yes ☐ Unknown
☐ No

Did the patient have another diagnosis/etiology for their illness?
☐ Yes ☐ Unknown
☐ No

Did the patient have an abnormal chest X-ray?
☐ Yes ☐ Unknown
☐ No

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

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

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
☐ Community contact with another lab-confirmed COVID-19 case-patient
☐ Any healthcare contact with another lab-confirmed COVID-19 case-patient
☐ Patient ☐ Visitor ☐ HCW
☐ Animal exposure
☐ Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology
☐ Other, specify:_____
☐ Unknown

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

Under what process was the PUI or case first identified? (check all that apply): ☐ Clinical evaluation leading to PUI determination
☐ Contact tracing of case patient ☐ Routine surveillance ☐ EpiX 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

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

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

Additional CCBH Case Variable Collected

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

Constitutional sx incl. headache & fatigue: *Date of Onset* __/__/__

Note: Italicized text represents additional data points added and collected by CCBH.

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	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Other chronic diseases	☐Yes	☐No	☐Unknown	(If YES, specify) _____
If female, currently pregnant	☐Yes	☐No	☐Unknown	
Current smoker	☐Yes	☐No	☐Unknown	
Former smoker	☐Yes	☐No	☐Unknown	

Respiratory Diagnostic Testing

Test	Pos	Neg	Pend.	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

Specimen Type	Specimen ID	Date Collected	Sent to CDC	State Lab Tested
NP Swab				
OP Swab				
Sputum				
Other, Specify: _____				

Location of Lab Testing:
☐*CC* ☐*UH* ☐*Metro*
*Other:*_____

Note: Italicized text represents additional data points added and collected by CCBH.

Additional State/local Specimen IDs: _____ _____ _____ _____ _____

Supplemental questions to:
Interim 2019 novel coronavirus (2019-nCoV) patient under investigation (PUI) form

For all identified PUIs, please complete this form in addition to the 2019-nCoV PUI form.

1. Today's date_____/_____/_____(mm/dd/yyyy)
2. State Patient ID (if available)_____
3. CDC PUI ID (if available)_____
4. Jurisdiction_____
5. Name of person completing form_____
6. Contact information of person completing form_____
7. Patient name (first & last)_____
8. Patient DOB_____/_____/_____(mm/dd/yyyy)
9. Patient temporary address (city, state, zip, country)

   _____

10. Patient permanent address (city, state, zip, country)

    _____

11. Patient phone_____
12. If patient is a student, name of school_____

Proceed to next page

13. **Travel History Outside of the United States** (from 14 days before symptom onset to present)
Note: ask about all international travel, including to China, and all cities visited (e.g. Wuhan City)

Location (city, province, country) Dates visited

a. _____

b. _____

c. _____

d. _____

e. _____

f. _____

g. _____

h. _____

14. **Places Visited within the United States** (from 14 days before symptom onset to present)
Note: ask about possible transmission settings, including where the patient might have worked, met with friends, ate, visited, etc.

Location (city, state, place visited) Dates visited

a. _____

b. _____

c. _____

d. _____

e. _____

f. _____

g. _____

h. _____

i. _____

j. _____

If you need more space, please add information to the blank page at the end of this form.

15. **Modes of Travel** (from 14 days before symptom onset to present)
Note: ask about travel by plane, bus, train, private vehicles, etc.

	Travel mode	Departure location/date/time	Arrival location/date/time	Carrier/Seat #
a.				
b.				
c.				
d.				
e.				
f.				
g.				
h.				
i.				
j.				

16. **Exposure to Healthcare Facilities** (from 14 days before symptom onset to present)
Note: ask about healthcare facility exposures as either a patient or as a visitor

	Facility type	Name	Location	Reason for visit	Dates admitted/visited
a.					
b.					
c.					
d.					
e.					

If you need more space, please add information to the blank page at the end of this form.

Case No:	*Name:*	*Case DOB:*	*Date of Symptom Onset:*

Name	*Relationship to Patient*	*Contact Numbers*	*Date of Contact with Symptomatic Case:* ***(Additional CCBH Info.)***
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			

**Note: Italicized text represents additional collection information for CCBH use.*

If you need more space, please add information to the blank page at the end of this form.

Please use this space to include any additional notes:

ACTIVITY LOG (ICS 214)

1. Incident Name:	2. Operational Period: Date From: Time From:	Date To: Time To:

3. Name:	4. ICS Position:	5. Home Agency (and Unit):

6. Resources Assigned:

Name	ICS Position	Home Agency (and Unit)

7. Activity Log:

Date/Time	Notable Activities

8. Prepared by: Name: _____ Position/Title: _____ Signature: _____

 Date/Time: _____

ACTIVITY LOG (ICS 214)

1. Incident Name:	**2. Operational Period:** Date From: Date To: Time From: Time To:

7. Activity Log (continuation)**:**

Date/Time	Notable Activities

8. Prepared by: Name: ____________________ Position/Title: ___________________ Signature: _____________________

ICS 214, Page 2	Date/Time: ____