

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

Patient's or Parent/Guardian name (for minors):	Patient's phone:
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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](#).

Unique ID (CountyName_###, e.g. Clark_001):		Reporting county:	
Patient's county of residence:	State:	Residency: <input type="checkbox"/> US resident <input type="checkbox"/> non US resident If non US resident, nationality:	
Interviewer's name:		Phone:	Email:
Date of report:	<input type="checkbox"/> New report <input type="checkbox"/> 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: <input type="checkbox"/> Fever <input type="checkbox"/> Runny Nose <input type="checkbox"/> Sneezing <input type="checkbox"/> Cough <input type="checkbox"/> Sore Throat <input type="checkbox"/> Shortness of Breath Other symptoms:			
5. Did patient travel to Middle East in the 10 days prior to illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  If yes, which countries? Depart Date    Return Date    Location 1) 2)		6. Did patient have contact with <u>someone else</u> who traveled to the Middle East in the 10 days prior to illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Cows <input type="checkbox"/> Bats <input type="checkbox"/> Goats <input type="checkbox"/> Camels <input type="checkbox"/> Sheep <input type="checkbox"/> Other animals If other, what animals?		8. Does patient work as a health care worker? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, name and city of facility:	
9. Diagnosis of pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes: <input type="checkbox"/> Clinical <input type="checkbox"/> Radiographic <input type="checkbox"/> Other If other:		10. Was the patient hospitalized for this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Hospitalization Date:                      Discharge Date: If Yes, hospital name & city:	
11. Admitted to ICU <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown ICU Start Date: ICU Discharge Date:		12. Mechanical Ventilation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If known, Start Date: Duration (days):	
		13. Acute Respiratory Distress Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date:	
		14. Renal failure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
		15. Fatality <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
16. Did patient have any tests performed for respiratory viruses/bacteria? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown    If Yes, ID#:			
18. Did patient have contact with a person with ARI in the 10 days prior to illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, describe (e.g., Case is sibling of a confirmed case)			

**TO REPORT A CASE, PLEASE CONTACT COUNTY OF RIVERSIDE DISEASE CONTROL AT (951) 358-5107 AND FAX THIS FORM TO: (951) 358-5102.**

Please forward any available medical records (e.g., H&P, micro reports, discharge summary, autopsy report, etc.) to Disease Control ASAP for review of cases.