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

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.

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:**
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17. Is a specimen being sent to CDC for testing? ☐ Yes ☐ No ☐ Unknown If 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)*

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.

REVIEWED March 6, 2013