Revised case report form for Confirmed Novel Coronavirus COVID-19 (report to WHO within 48 hours of case identification)

27 February 2020

Date of reporting to national health authority: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Reporting country: _____

Why tested for COVID-19:

□ Contact of a case □ Ill Seeking Healthcare due to suspicion of COVID-19 □ Detected at point of entry □ Repatriation
□ Routine respiratory disease surveillance systems (e.g. influenza) □ Unknown

If none of the above, please explain: _____

Section 1: Patient information

Unique Case Identifier (used in country): _____

Age (years): [__][__][__] if <1 year old, [__][__] in months or if < 1 month, [_][__] in days Sex at birth: □ Male □ Female

Place where the case was diagnosed: Country: _____
Admin Level 1 (province): _____

Case usual place of residency: Country: _____

Section 2: Clinical Status

Date of first laboratory confirmation test: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Any symptoms* or signs *at time of specimen collection that resulted in first laboratory confirmation*?

□ No (i.e., asymptomatic) □ Yes □ Unknown

If yes, date of onset of symptoms: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Underlying conditions and comorbidity:

Any underlying conditions? □ No □ Yes □ Unknown

If yes, please check all that apply:

□ Pregnancy (trimester:_____)
□ Cardiovascular disease, including hypertension
□ Diabetes
□ Liver disease
□ Chronic neurological or neuromuscular disease
□ Other(s), please specify:
□ Post-partum (< 6 weeks)
□ Immunodeficiency, including HIV
□ Renal disease
□ Chronic lung disease
□ Malignancy

Health Status at time of reporting:

Admission to hospital: □ No □ Yes □ Unknown
First date of admission to hospital: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

If yes
Did the case receive care in an intensive care unit (ICU)? □ No □ Yes □ Unknown
Did the case receive ventilation? □ No □ Yes □ Unknown
Did the case receive extracorporeal membrane oxygenation? □ No □ Yes □ Unknown

Is case in isolation with Infection Control Practice in place □ No □ Yes □ Unknown
Date of isolation: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Section 3: Exposure risk in the 14 days prior to symptom onset (prior to testing if asymptomatic)

Is case a Health Care Worker (any job in a health care setting): □ No □ Yes □ Unknown

If yes, Country:_____City:_____ Name of Facility: _____

Has the case **travelled** in the 14 days prior to symptom onset? □ No □ Yes □ Unknown
If yes, please specify the places the patient travelled to and date of departure from the places:

	Country	**City**	**Date of Departure from the place**
1.	Country_____	City _	Date_____
2.	Country_____	City _	Date_____ Date _ _____
3.	Country_____	City _	

Has case **visited any health care facility** in the 14 days prior to symptom onset? □ No □ Yes □ Unknown

Has case **had contact with a confirmed case** in the 14 days prior to symptom onset? □ No □ Yes □ Unknown
If yes, please list unique case identifiers of all probable or confirmed cases:
If yes, please explain contact setting:_____
_____

	Contact ID	**First Date of Contact**	**Last Date of Contact**
1.	_____	Date _____	Date _____
2.	_____	Date _____	Date _____
3	_____	Date _____	Date _____
4	_____	Date _____	Date _____
5	_____	Date _____	Date _____

Most likely country of exposure: _____

World Health Organization

Section 4: Outcome : complete and re-sent the full form as soon as outcome of disease is known or after 30 days after initial report.

Date of re-submission of this report: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

If case was asymptomatic at time of specimen collection resulting in first laboratory confirmation, did the case develop any symptoms or signs *at any time* prior to discharge or death:

□ No (i.e., case remains asymptomatic)

□ Yes, asymptomatic case (as previously reported) developed symptoms and/or signs of illness

If yes, date of onset of symptoms/signs of illness: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

□ Unknown

Clinical Course:

Admission to hospital (may have been previously reported): □ No □ Yes □ Unknown

If admitted to hospital:

First date of admission to hospital: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Did the case receive care in an intensive care unit (ICU)? □ No □ Yes □ Unknown

Did the case receive ventilation? □ No □ Yes □ Unknown

Did the case receive extracorporeal membrane oxygenation? □ No □ Yes □ Unknown

Health Outcome: □ Recovered/Healthy □ Not recovered □ Death □ Unknown: □

Other: If other, please explain: _____

Date of Release from isolation/hospital or Date of Death: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]