VDH VIRGINIA DEPARTMENT OF HEALTH

Enter information into VEDSS and attach this case report form to the VEDSS investigation if requested.

VEDSS ID:_____
COVIDWISE PIN:_____
Outbreak ID:_____
MMWR Week/Year:_____Week_____Year
Case Classification: ☐ Confirmed ☐ Probable ☐ Suspect

Coronavirus Disease 2019 (COVID-19) Case Report Form

PATIENT INFORMATION

Name (Last, First, Middle Initial): _____

Current Address:

_____

City/**State**/Zip: _____

County: _____

Country of Usual Residence: _____

Phone Number(s)/Email: _____

Preferred Contact Method (SARA Alert): ☐ E-mailed Web Link ☐ SMS Text-message ☐ SMS Texted Weblink ☐ Telephone call

Alternative Contact: ☐ Parent/Guardian ☐ Spouse ☐ Other: _____

Alt. Contact Name: _____ Phone Number: (____) _____ - _____

Patient Occupation: _____

Workplace/School/Childcare Name: _____

School Grade (Pre-K to 12th): _____

Date of Birth: ____/____/_____

Age: _____ ☐ **Years** ☐ **Months**

Country of Birth: _____

Sex: ☐ Male ☐ Female ☐ Unk

Ethnicity:
☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unk

Race: (Select all that apply)
☐ American Indian/AK Native
☐ Black/Afr. American ☐ Asian
☐ Native HI/Other PI ☐ White
☐ Refused to Answer ☐ Other
☐ Not Asked ☐ Unk

Does this case have any tribal affiliation?:
☐ Yes ☐ No ☐ Unk
Tribe Name: _____
Enrolled tribe member?:
☐ Yes ☐ No ☐ Unk

Height: _____ Weight: _____

COVID-19 CASE DETAILS

CDC 2019-nCoV ID: _____

Under what process was the case first identified? (Select all that apply)
☐ Clinical evaluation
☐ EpiX notification of travelers
☐ Routine surveillance
☐ Contact tracing of case patient
☐ Patient under investigation (PUI)
☐ Other: _____ ☐ Unk

If EpiX notification of travelers, DGMQ ID: _____

REPORTING INFORMATION

Earliest Report to Public Health: ____/____/_____

Investigation Start Date: ____/____/_____

Reporting (select only one): ☐ Lab ☐ Hospital ☐ HCP[1] ☐ Public Health Agency ☐ Other: _____

Reporting Organization: _____

Reporting Organization Phone Number: (_____) _____ - _____

Primary Provider Name: _____

Primary Provider Phone Number: (_____) _____ - _____

CLINICAL INFORMATION

Was the patient hospitalized for this illness?
☐ Yes ☐ No ☐ Unk

Name of Hospital: _____

Admit date: ____/____/_____

Discharge date: ____/____/_____

Total duration of stay in the hospital (days): _____

If hospitalized, was an interpreter required?
☐ Yes ☐ No ☐ Unk

If yes, specify which language(s):_____

Yes	No	Unk	
☐	☐	☐	Was the patient admitted to an intensive care unit (ICU)? Admit date: ____/____/_____ Discharge date: ____/____/_____
☐	☐	☐	Did the patient receive mechanical ventilation (MV)/intubation?: Total days with mechanical ventilation: ___
☐	☐	☐	Did the patient receive ECMO?
☐	☐	☐	**Did the patient die from this illness?** Date of death: ____/____/_____
☐	☐		Unknown date of death

[1]Healthcare Personnel

PLACE OF RESIDENCE

Which would best describe where the patient was staying at the time of illness onset?

☐ Acute care inpatient facility ☐ Apartment ☐ Correctional facility ☐ Other: _____
☐ Group home ☐ Homeless shelter ☐ Hotel/motel
☐ House/single family home ☐ Longterm care facility ☐ Mobile home ☐ Unk
☐ Nursing home/assisted living facility ☐ Outside, in a car, other location not meant for human habitation ☐ Rehabilitation facility

Was the patient incarcerated at the time of specimen collection?: ☐ Yes ☐ No ☐ Unk

If yes, incarcerated location?:
☐ Federal prison ☐ Juvenille detention ☐ Local jail ☐ Regional jail ☐ Other: _____

EPIDEMIOLOGIC DATA

Is this case part of an outbreak? ☐ Yes ☐ No ☐ Unk **If yes, outbreak name**: _____

COVID-19 Variant: ☐ B.1.1.7 (501Y.V1), VOC ☐ B.1.351 (501Y.V2), VOC ☐ P.1 (501Y.V3), VOC ☐ Other Variant Type: _____

Does the patient meet the definition for vaccine breakthrough infection? ☐ Yes ☐ No ☐ Unk

Is the patient a healthcare worker in the United States?: ☐ Yes ☐ No ☐ Unk

If yes, what is their occupation (type of job?):
☐ Environmental services ☐ Nurse ☐ Physician ☐ Respiratory Therapist ☐ Other: _____ ☐ Unk

If yes, what is their job setting?:
☐ Hospital ☐ Longterm care facility ☐ Nursing home/assisted living facility
☐ Rehabilitation facility ☐ Other: _____ ☐ Unk

TRAVEL AND EXPOSURE HISTORY

In the 14 days prior to illness onset, did the patient have any of the following exposures (indicate all that apply):

Domestic travel (outside normal state of residence): ☐ Yes ☐ No ☐ Unk Specify state(s): _____

International travel: ☐ Yes ☐ No ☐ Unk Specify country(s): _____

Cruise ship or vessel travel as passenger or crew member: ☐ Yes ☐ No ☐ Unk

Specify name of ship or vessel: _____

In the 14 days prior to illness onset, did the patient have workplace, congregate, animal or other exposures? ☐ Yes ☐ No ☐ Unk

Yes	No	Unk		Yes	No	Unk	
☐	☐	☐	Workplace	☐	☐	☐	School/University/Childcare center
☐	☐	☐	If yes, is the workplace critical infrastructure (e.g. healthcare setting, grocery store)?	☐	☐	☐	Correctional facility
				☐	☐	☐	Community event/mass gathering
			If yes, specify workplace setting: _____	☐	☐	☐	Animal with confirmed or suspected COVID-19
							Specify type of animal: _____
☐	☐	☐	Airport/airplane	☐	☐	☐	Other exposure (specify): _____
☐	☐	☐	Adult congregate living facility (nursing home, assisted living facility, or LTC facility).	☐	☐	☐	Unknown exposure in the 14 days prior to illness onset

Exposure facility or event name: _____

Yes	No	Unk		Yes	No	Unk	
☐	☐	☐	**Did the patient have contact with another COVID-19 case (probable or confirmed)?**	☐	☐	☐	If the patient had contact with another COVID-19 case, was this person a U.S. case?
☐	☐	☐	Household contact				nCoV ID of source case 1: _____
☐	☐	☐	Community contact				nCoV ID of source case 2: _____
☐	☐	☐	Healthcare contact				nCoV ID of source case 3: _____

Please Fill Out the Suspected Exposure Location (Where the Patient Likely Acquired the Disease During the Exposure Period):

Country	State	City	County

SCHOOL EXPOSURE

Is patient currently enrolled or working in school/college/childcare? (Childcare; College/University; K-12; Unk)	Is the patient a student/attendee or employee? (Employee; Student/attendee)	If yes to K-12 or college, what type of learning are they participating in as a student or teacher? (Hybrid - In-person/remote; In person; Remote only)

SIGNS AND SYMPTOMS

Diagnosis date: ____/____/_____

Date of first positive specimen collection: _____/____/_____

Yes	No	Unk		Yes	No	Unk	
☐	☐	☐	Did the patient develop pneumonia?	☐	☐	☐	Did the patient have an abnormal chest X-ray?
☐	☐	☐	Did the patient have acute respiratory distress syndrome?	☐	☐	☐	Did the patient have an abnormal EKG?
☐	☐	☐	Did the patient have another diagnosis/ etiology for their illness?				

Symptoms present during the course of illness: ☐ Yes ☐ No ☐ Unk

Date of symptom onset[2]: ____/____/_____ Date of symptom resolution: ____/____/_____ Illness duration: _____

Age at onset: _____ Age at onset units: _____

If symptomatic, symptom status: ☐ Still symptomatic ☐ Symptoms resolved ☐ Symptoms resolved, unknown date ☐ Unknown symptom status

If symptoms were present during the course of illness, please answer the following questions:

Yes	No	Unk		Yes	No	Unk	
☐	☐	☐	Measured Fever Highest Measured Temperature: _____	☐	☐	☐	Shortness of Breath (dyspnea)
☐	☐	☐	Subjective fever (felt feverish)	☐	☐	☐	Difficulty Breathing
☐	☐	☐	Chills	☐	☐	☐	Nausea or Vomiting
☐	☐	☐	Rigors	☐	☐	☐	Headache
☐	☐	☐	Muscle aches (myalgia)	☐	☐	☐	Abdominal Pain or Tenderness
☐	☐	☐	Fatigue or malaise	☐	☐	☐	Chest pain
☐	☐	☐	Runny nose (rhinorrhea)	☐	☐	☐	Diarrhea (=3 loose/looser than normal stools/24hr period)
☐	☐	☐	Sore Throat	☐	☐	☐	Loss of appetite
☐	☐	☐	Cough (new onset or worsening of chronic cough)	☐	☐	☐	New Olfactory and Taste Disorder
☐	☐	☐	Wheezing	☐	☐	☐	Other symptoms: _____

Symptom notes:

[2]If asymptomatic, use positive specimen collection date

MEDICAL HISTORY

Did the patient have any pre-existing medical conditions?: ☐ Yes ☐ No ☐ Unk

If yes, please answer the following questions:

Is the patient pregnant?: ☐ Yes ☐ No ☐ Unk If yes, due date: ____/____/_____

Yes	No	Unk		Yes	No	Unk	
☐	☐	☐	Chronic Lung Disease (asthma/emphysema/ COPD)	☐	☐	☐	Disability If yes, specify: _____
☐	☐	☐	Diabetes Mellitus	☐	☐	☐	Psychological or Psychiatric Condition If yes, specify: _____
☐	☐	☐	Hypertension				
☐	☐	☐	Cardiovascular disease	☐	☐	☐	Other Chronic Diseases If yes, specify: _____
☐	☐	☐	Chronic Renal disease	☐	☐	☐	Other Underlying Condition or Risk Behavior If yes, specify: _____
☐	☐	☐	Chronic Liver disease				
☐	☐	☐	Severe Obesity (BMI >=40)	☐	☐	☐	Current smoker
☐	☐	☐	Immunosuppressive Condition	☐	☐	☐	Former smoker
☐	☐	☐	Autoimmune Condition	☐	☐	☐	Substance Abuse or Misuse

COVID-19 LABORATORY FINDINGS

Was laboratory testing performed?: ☐ Yes ☐ No ☐ Unk If yes, please fill out the following section:

Test Type	Performing Lab[1]	Specimen Collection Date	Specimen ID	Specimen Source[2]	Result[3]	Specimen Sent to Public Health Lab?	Date Specimen Sent to Public Health Lab	State Lab Specimen ID Number
SARS CoV2 PCR		/ /					/ /	
SARS CoV2 Antigen		/ /					/ /	
Other:		/ /					/ /	

Performing Lab[1]

1. CDC lab
2. Commercial lab
3. Public health lab

Specimen Source[2]

1. Blood/serum
2. Nasopharyngeal
3. Oropharyngeal
4. Other, specify
5. Sputum

Test Result[3]

1. Positive
2. Negative
3. Indeterminate
4. Not done
5. Pending

Test Result Comments

Additional Specimen ID

INVESTIGATOR

Investigator: _____ Phone/Email: _____

Investigation Complete Date: ____/____/_____ Local Health Jurisdiction: _____

What was the earliest date on which an interview was attempted?: ____/____/_____

What was the date the initial interview was completed?: ____/____/_____

Did the individual provide close contacts for tracing?: ☐ Yes ☐ No

If yes, how many contacts were entered into Sara Alert?: _____

Interview Status:

☐ Completed ☐ Lost to follow-up ☐ Not Attempted ☐ Partially completed ☐ Refused or unable to interview

COMMENTS

Vaccination History

Did the patient ever receive a COVID-containing vaccine? ☐ Yes ☐ No ☐ Unk

If yes: 1) Number of Vaccination Doses Prior to Onset? _____

2) Date of Last Dose Prior to Illness Onset: _____/___/_____

3) Vaccinated per ACIP Recommendations? ☐Y ☐N (if no, also answer Question 4 below) ☐Unk

If no: 4) Reason not vaccinated?

☐Born outside of U.S.
☐Lab evidence of previous disease
☐Medical Contraindication
☐MD diagnosis of previous disease
☐Never offered vaccine
☐Parent/Patient forgot to vaccinate
☐Parent/Patient refusal
☐Parent/Patient report of disease
☐Philosophical objection
☐Religious exemption
☐Too Young
☐Unk
☐Other: _____

Notes pertaining to patient's vaccination history:

List the Vaccination Information below: ** Entered in the VEDSS patient Vaccinations.*

Vaccination Date	Vaccine Administered	Vaccine Manufacturer	Vaccine Lot Number
/ /			
/ /			