COVID-19 CASE INVESTIGATION FORM

Name of Reporting Centre

Specimen ID

1. Patient Information

First Name Last Name

Sex
☐Female
☐Male

Date of Birth
(dd/mm/yyyy)
/ /

Address in the last 14 days

House Number Street Name City/Settlement/Cay Island Country

Phone Numbers

Mobile

Home

Work

Government ID

Type ☐Passport ☐NIB

Number

Nationality

Occupation

☐Construction ☐Financial services ☐Hospitality ☐Retail ☐Student ☐Uniformed branches
☐Clergy ☐Healthcare provider ☐Journalism/Broadcasting ☐Retired ☐Trade ☐Other
☐Education ☐Homemaker ☐Legal ☐Self-employed ☐Unemployed

Place of employment

2. Testing

Reason for Testing

☐For travel ☐Exposure to Confirmed Case
☐Re-entry into Workplace ☐Screening
☐COVID-19 Symptoms ☐Other

3. Symptomatology

Asymptomatic ☐Yes ☐No

Symptoms

☐Abdominal pain ☐Fatigue ☐Loss of taste
☐Chills ☐Fever ☐Loss of smell
☐Diarrhea ☐Headache ☐Shortness of breath
☐Dry cough ☐Myalgia ☐Vomiting

Date of onset of illness
(dd/mm/yyyy)
/ /

4. Exposure History

Travel History

Domestic travel within the last 14 days? ☐Yes ☐No
If yes, where?

International travel within the last 14 days? ☐Yes ☐No
If yes, where?

Date of Domestic Travel
(dd/mm/yyyy)
/ /

Date of International Travel
(dd/mm/yyyy)
/ /

Contact with Known Case

Was there close contact with a known positive case within the past 14 days? ☐Yes ☐No
(Close contact is defined as contact for more than 15minutes and within less than 6feet)

Date of Exposure
(dd/mm/yyyy)
/ /

5. Vital Status

☐Deceased ☐Alive

Date of Death
(dd/mm/yyyy)
/ /

Disposition

Is/was the patient hospitalized? ☐Yes ☐No
If yes, where?

Date of Hospitalization
(dd/mm/yyyy)
/ /

6. Laboratory data

Real-time PCR completed? ☐Yes ☐No

Sample Type	Date Specimen Taken (dd/mm/yyyy)	Date Received by Lab (dd/mm/yyyy)	Result	Date of Result (dd/mm/yyyy)
Nasopharyngeal swab	/ /	/ /		/ /
Oropharyngeal swab	/ /	/ /		/ /
Saliva	/ /	/ /		/ /

Rapid Antigen Surveillance Test completed? ☐Yes ☐No

Sample Type	Date Specimen Taken (dd/mm/yyyy)	Date Received by Lab (dd/mm/yyyy)	Result	Date of Result (dd/mm/yyyy)
Nasopharyngeal swab	/ /	/ /		/ /
Oropharyngeal swab	/ /	/ /		/ /
Saliva	/ /	/ /		/ /

7. Additional Comments

ADDITIONAL NOTES MAY BE WRITTEN OVERLEAF