



Coronavirus Disease 2019 (COVID-19) Case Report Form

Contact Information						use date format: (MM/DD/YY)
Merlin Case ID	<input type="checkbox"/> New Report <input type="checkbox"/> Update to previous report		Date CHD Notified (/ /)			
			Report Date (/ /)			
Reporting County	Interviewer Name	Interviewer Phone	Interviewer Email			
Person Name (Last, First, M.I.):		Parent/Guardian Name (if Minor)		Person or Guardian Phone		
Person Address: Number, Street, Apt #		City	County		State	ZIP Code
Reporting Facility Name (Hospital/Lab)		Reporting Facility Phone		IP's Name		Physician's Name
Reporting Facility Address			City	County		State
					State	ZIP Code

Demographic Information						use date format: (MM/DD/YY)	
Date of Birth (/ /)		Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unk		Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unk		
Race (check one) <input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Other: _____				Patient is a health care worker <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			

Symptoms, Treatment		use date format: (MM/DD/YY)
Illness onset date (/ /)	Person was symptomatic at initial interview <input type="checkbox"/> Yes <input type="checkbox"/> No, date person felt back to normal: (/ /) <input type="checkbox"/> Unk	

Check all symptoms that the person has experienced during illness and include date of onset:

<input type="checkbox"/> Fever (/ /) <input type="checkbox"/> No	<input type="checkbox"/> Measured, highest temp: ____ <input type="checkbox"/> Subjective	<input type="checkbox"/> Asymptomatic
<input type="checkbox"/> Dry cough (/ /) <input type="checkbox"/> No	<input type="checkbox"/> Shortness of breath (/ /) <input type="checkbox"/> No	<input type="checkbox"/> Productive cough (/ /) <input type="checkbox"/> No
<input type="checkbox"/> Muscle aches (/ /) <input type="checkbox"/> No	<input type="checkbox"/> Headache (/ /) <input type="checkbox"/> No	<input type="checkbox"/> Abdominal pain (/ /) <input type="checkbox"/> No
<input type="checkbox"/> Vomiting (/ /) <input type="checkbox"/> No	<input type="checkbox"/> Chills (/ /) <input type="checkbox"/> No	<input type="checkbox"/> Runny nose (/ /) <input type="checkbox"/> No
<input type="checkbox"/> Nausea (/ /) <input type="checkbox"/> No	<input type="checkbox"/> Diarrhea (/ /) <input type="checkbox"/> No	<input type="checkbox"/> Loss of taste/smell (/ /) <input type="checkbox"/> No
<input type="checkbox"/> Sore throat (/ /) <input type="checkbox"/> No	<input type="checkbox"/> Fatigue/weakness (/ /) <input type="checkbox"/> No	<input type="checkbox"/> Other, specify: _____ (/ /) <input type="checkbox"/> No

Clinical Information:			
Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			
Did person die as a result of this illness?		<input type="checkbox"/> Yes, date of death (/ /) <input type="checkbox"/> No <input type="checkbox"/> Unk	
Was person hospitalized for this illness?		<input type="checkbox"/> Yes, date of admission (/ /) <input type="checkbox"/> No <input type="checkbox"/> Unk Room # _____	

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Contact Tracing

Does the person have any close contacts? Yes No Unk

Person had close contact with a laboratory-confirmed COVID-19 case Yes No Unk

Potential Source Cases¹ (people who may have infected this case): None

Name (last, first)	Merlin ID	Phone #	Date of last contact	Relationship

People this case exposed (for confirmed cases only): None

Name (last, first)	Date of birth (MM/DD/YY)	Merlin ID	Phone #	Date of last contact	Relationship

Follow-up attempts:

Date	Time	Phone #	Outcome	Symptomatic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Method

Outcome at final contact attempt: _____ Date criteria for discontinuing isolation met: (/ /)

Reason lost to follow-up: _____ Checked for contact information: Yes No Unk

At least 3 contact attempts made: Yes No Unk

¹The infectious period is 2 days before symptoms onset (or specimen collection for asymptomatic cases) through the date they meet criteria for discontinuing isolation. Close contact is defined as being within 6 feet of a confirmed case for more than 15 minutes.

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Group Settings:

Person lives in a group setting Yes No

Person works in a group setting Yes No

Group setting type ALF Nursing home LTCF Correctional/Unit # _____ Other: _____

Group setting name

Group setting address

Clinical Information (extended)

Medical Record received: Yes No Unk

Height: _____ cm

Weight: _____ kg

BMI: _____ kg/m²

Check all diagnoses person has received and include date of diagnosis:

None

Abnormal chest X-ray (/ /) Abnormal chest CT (/ /) Pneumonia (/ /) ARDS (/ /)

Renal Failure (/ /) Multisystem Inflammatory syndrome (/ /) Other, specify: _____ (/ /)

Check all underlying health conditions of the person:

None

Current smoker Former smoker Obesity Diabetes Chronic Lung Disease Asthma

Chronic obstructive pulmonary disease (COPD) Chronic Kidney Disease Chronic Liver Disease Cardiac Disease

Hypertension Neurologic/neurodevelopmental, specify: _____

Immunocompromised, specify: _____ Other, specify: _____

If hospitalized:

Patient admitted to ICU Yes No Unk

Patient on ECMO Yes No Unk

Patient received mechanical ventilation (MV)/intubation

Yes, total days with MV: _____ No Unk

Testing

Specify all non-COVID-19 testing performed:

Test Type	Specimen Collection Date (MM/DD/YY)	Result
<input type="checkbox"/> Influenza: Rapid test		<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Other: _____
<input type="checkbox"/> Influenza: PCR		<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Other: _____
<input type="checkbox"/> Influenza: Other test		<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Other: _____
<input type="checkbox"/> Respiratory syncytial virus		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending
<input type="checkbox"/> Human metapneumovirus		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending
<input type="checkbox"/> Adenovirus		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending
<input type="checkbox"/> Parainfluenza 1-4		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending
<input type="checkbox"/> Rhinovirus/enterovirus		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending
<input type="checkbox"/> Coronavirus (OC43, 229E, HKU1, NL63)		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending
<input type="checkbox"/> <i>Legionella pneumophila</i>		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending
<input type="checkbox"/> <i>Streptococcus pneumoniae</i>		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending
<input type="checkbox"/> <i>Mycoplasma pneumoniae</i>		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending
<input type="checkbox"/> <i>Chlamydia pneumoniae</i>		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending
<input type="checkbox"/> Blood culture		Specify organisms