

**Coronavirus Disease 2019 (COVID-19)
Interim Person Screening Form**

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

- Pneumonia (/ /) ARDS (/ /) Renal Failure (/ /)
 Abnormal chest X-ray (/ /) Other, specify: _____ (/ /)

Check all underlying health conditions of the person:

- Diabetes Chronic Lung Disease Chronic Kidney Disease Chronic Liver Disease Cardiac Disease
 Hypertension Immunocompromised, specify: _____ Neurologic/neurodevelopmental, specify: _____ Other, specify: _____

Person is pregnant Yes No Unk

Current smoker Yes No Unk Former smoker Yes No Unk

Patient has a non-COVID-19 etiology for their respiratory illness but has not responded to appropriate therapy Yes, specify: _____ No Unk

Specify locations where person sought medical care for their illness:

Location	Earliest date (MM/DD/YY)	Details
<input type="checkbox"/> Doctor's Office		
<input type="checkbox"/> Health Department		
<input type="checkbox"/> Urgent Care Clinic		
<input type="checkbox"/> Emergency Department		
<input type="checkbox"/> Other		
<input type="checkbox"/> Unknown		

Was person hospitalized for this illness? Yes, date of admission (/ /) No Unk

Did person die as a result of this illness? Yes, date of death (/ /) No Unk

Risk Factors

In the 14 days before symptom onset:

Person traveled to or from geographic region with sustained community transmission <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Destinations and dates including arrival to the US
Person had travel companions <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Names and phone numbers of travel companions
Person traveled to or from mainland China <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Destinations and dates including arrival to the US
In China, person in a health care facility as a patient, worker, or visitor <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Dates and details of exposure
Patient is a health care worker in the US <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	

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Risk Factors

In the 14 days before symptom onset:

Person had close contact¹ with a laboratory-confirmed COVID-19 case Yes No Unk

Case was ill at time of contact Yes No Unk

Case was reported in US Outside US If outside US, specify country

Types of contact:

Household contact Yes No Unk

Community contact Yes No Unk

Health care contact Yes No Unk

Person status at time of health care contact with lab-confirmed COVID-19 case:

Patient Yes No Unk

Visitor Yes No Unk

Health care worker Yes No Unk

Person is a member of a cluster of patients with medically attended respiratory illness of unknown etiology in which COVID-19 is being evaluated in consultation with state and local health departments Yes No Unk

Person's relationship to each cluster member

Person Contact

If hospitalized:

Patient is/was in a negative pressure room Yes No Unk Patient admitted to ICU Yes No Unk

Patient is/was in a private room Yes No Unk Patient on ECMO Yes No Unk

Patient received mechanical ventilation (MV)/intubation Yes, total days with MV:_____ No Unk

PPE health care personnel used when caring for patient or obtaining specimens N95 Mask Facemask Gloves None Surgical mask Eye Protection Gown Unk

At time of interview, person was currently at a health care facility Yes No Unk

If yes:

Patient used surgical mask during transport within current health care facility Yes No Unk

¹ Close contact is defined as a) being within approximately 6 feet (2 meters), or within the room or care area, of a COVID-19 case for a prolonged period of time while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection); close contact can include caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case; or b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on) while not wearing recommended personal protective equipment. Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to those exposed in health care settings.

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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			

Specify all specimens collected for COVID-19 testing:

Specimen	Collection Date (MM/DD/YY)	Sent to BPHL	
<input type="checkbox"/> Sputum		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Tracheal aspirate (TA)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Bronchial alveolar lavage (BAL)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Nasopharyngeal (NP)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Oropharyngeal (OP)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Serum		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Stool		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Urine		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other Notes