NC Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

COVID-19 (Coronavirus Infection)

CONFIDENTIAL COMMUNICABLE DISEASE REPORT – PART 2

ATTENTION Local Health Department Staff. Enter all information from this form into the NC COVID question packages.

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias

Birthdate (mm/dd/yyyy): / /	SSN:	Gender: ☐ M ☐ F ☐ M to F ☐ F to M

Patient Street Address	City	State	ZIP	County	Phone ( ) -

NC COVID LAB RESULTS – Verify if lab results for this event are in NC COVID. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name –City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

CLINICAL FINDINGS

Is/was patient symptomatic for this disease? ☐ Y ☐ N ☐ U
If yes, earliest (1st) symptom onset date (mm/dd/yyyy): ___/___/_____
Fever ☐ Y ☐ N ☐ U
☐ Yes, subjective ☐ No
☐ Yes, measured ☐ Unknown
Highest measured temperature_____
Fever onset date (mm/dd/yyyy): ___/___/_____
Sweats (diaphoresis) ☐ Y ☐ N ☐ U
Chills or rigors ☐ Y ☐ N ☐ U
Headache ☐ Y ☐ N ☐ U
Muscle Aches ☐ Y ☐ N ☐ U
Sore Throat ☐ Y ☐ N ☐ U
Cough ☐ Y ☐ N ☐ U
Onset date (mm/dd/yyyy): ___/___/_____
Productive ☐ Y ☐ N ☐ U
If yes, describe (check all that apply)
☐ Clear ☐ Purulent ☐ Bloody (hemoptysis)
Shortness of breath/difficulty breathing/ respiratory distress ☐ Y ☐ N ☐ U
Acute Respiratory Distress Syndrome (ARDS) ☐ Y ☐ N ☐ U
Did the patient have chest x-ray? ☐ Y ☐ N ☐ U
Date performed:……___/___/_____
If yes, describe (check all that apply)
☐ Normal ☐ Infiltrate
☐ Diffuse infiltrates/findings suggestive of ARDS
☐ Pleural effusion ☐ Other
Pneumonia …… ☐ Y ☐ N ☐ U
Confirmed by x-ray or CT……☐ Y ☐ N ☐ U

Vomiting …… ☐ Y ☐ N ☐ U
Abdominal pain/cramps…… ☐ Y ☐ N ☐ U
New olfactory & taste disorder(s)…… ☐ Y ☐ N ☐ U
Diarrhea …… ☐ Y ☐ N ☐ U
Describe (select all that apply)
☐ Bloody ☐ Non-bloody ☐ Watery ☐ Other
Other dx/etiology for respiratory illness?... ☐ Y ☐ N ☐ U
Other symptoms, signs, clinical findings, or complications consistent with this illness…… ☐ Y ☐ N ☐ U
If yes, please specify:

REASON FOR TESTING

Why was the patient tested for this condition?
☐ Symptomatic of disease
☐ Screening of asymptomatic person
☐ Resident/staff of adult congregate living facility
☐ Household contact to a person reported with this disease
☐ Non-household contact to a person reported with this disease
☐ Other, specify:
☐ Unknown

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐ Y ☐ N ☐ U

☐ Severe obesity (BMI ≥40)
☐ Diabetes
☐ Metabolic Disorder
☐ Hematologic Disorder
☐ Cardiovascular/ heart disease
☐ Kidney Disease
☐ Chronic Lung Disease
☐ Neuromuscular Disorder
☐ Moderate/severe dev disorder
☐ Seizure Disorder

Other Underlying Illness, specify:

TREATMENT

Did patient receive an antiviral for this illness? ☐ Y ☐ N ☐ U
Specify antiviral name: _____
Date treatment began(mm/dd/yyyy): ____/_____/_____
# of days taken (if known): _____
Did patient receive monoclonal antibodies (mAB) for this illness?
☐ Y ☐ N ☐ U Date started (mm/dd/yyyy): ___/___/_____
Specify mAb name: _____
Specify method of administration _____
Specify # of treatments: _____
Did patient require supplemental oxygen? ☐ Y ☐ N ☐ U
Did patient require intubation?..... ☐ Y ☐ N ☐ U
Did patient require mechanical ventilation/intubation?
☐ Y ☐ N ☐ U
# of days on ventilation/ intubated: _____
Was patient on ECMO? …… ☐ Y ☐ N ☐ U

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours?
☐ Y ☐ N ☐ U
Hospital name:_____
City, State:
Hospital contact name:
Telephone: ( ) -
Admit date (mm/dd/yyyy):…… ___/___/_____
Discharge date (mm/dd/yyyy):…… ___/___/_____
Number of Days Hospitalized
ICU admission?..... ☐ Y ☐ N ☐ U
Medical Record #

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias
Birthdate (mm/dd/yyyy): / /			SSN:		

ISOLATION/QUARANTINE/ CONTROL MEASURES

Restrictions to movement or freedom of action?..... ☐ Y ☐ N

Check all that apply:

☐ Work ☐ Child care ☐ School

☐ Sexual behavior ☐ Blood and body fluid

☐ Other, specify:

Date control measures issued: __/__/__

Date control measures ended: __/__/__

Was patient compliant with control measures?..... ☐ Y ☐ N

Local health director or designee implement additional control measures?..... ☐ Y ☐ N

If yes, specify:

Were written isolation orders issued?..... ☐ Y ☐ N

If yes, where was the patient isolated?

Date isolation started:..... __/__/__

Date isolation ended:..... __/__/__

Was the patient compliant with isolation?.... ☐ Y ☐ N

Were written quarantine orders issued?..... ☐ Y ☐ N

If yes, where was the patient quarantined?

Date quarantine started:..... __/__/__

Date quarantine ended:..... __/__/__

Was the patient compliant with quarantine?..... ☐ Y ☐ N

Comments about isolation and quarantine:

Are isolation support/ resources needed? ☐ Y ☐ N ☐ U

Were referrals made? ..... ☐ Y ☐ N ☐ U

TRAVEL & IMMIGRATION

The patient is:

☐ Resident of NC

☐ Resident of another state or US territory

☐ Foreign Visitor ☐ Refugee

☐ Recent Immigrant ☐ Foreign Adoptee

☐ None of the above

In the 14 days prior to illness onset, did the patient have any travel history? ..... ☐ Y ☐ N ☐ U

List travel dates and destinations:

From __/__/__ to __/__/__

Mode(s) of transportation (check all that apply)

☐ Airplane ☐ Train / subway

☐ Ship / boat / ferry ☐ On foot

☐ Automobile / motorcycle ☐ Bus / taxi / shuttle

☐ Other, specify:

CHILD CARE/SCHOOL/COLLEGE

Does patient attend child care?..... ☐ Y ☐ N ☐ U

In what county is child care center located:

Name of child care provider:

Did the patient attend child care in person during the exposure period (14 days prior to symptom onset or first positive test)?..... ☐ Y ☐ N ☐ U

Is patient a child care worker/volunteer? ☐ Y ☐ N ☐ U

In what county is child care center located:

Name of child care provider:

Did the patient work or volunteer child care in person during the exposure period (14 days prior to symptom onset or first positive test)?..... ☐ Y ☐ N ☐ U

Is patient a student?..... ☐ Y ☐ N ☐ U

In what county is the school located:

Type of school:

☐ NC public school (preK-12) ☐ NC private school (preK-12)

☐ Other school (preK-12) ☐ Community College

☐ College/University

☐ Other academic institution (trade school, professional)

Name of school:

Did the patient attend school in person during the exposure period (14 days prior to symptom onset or first positive test)?..... ☐ Y ☐ N ☐ U

Is patient a school worker/volunteer?... ☐ Y ☐ N ☐ U

In what county is the school located:

Type of school:

☐ NC public school (preK-12) ☐ NC private school (preK-12)

☐ Other school (preK-12) ☐ Community College

☐ College University

☐ Other academic institution (trade school, professional)

Name of school:

Did the patient work or volunteer at school in person during the exposure period (14 days prior to symptom onset or first positive test)?..... ☐ Y ☐ N ☐ U

CLINICAL OUTCOMES

Discharge/Final diagnosis:

Clinical Outcome:..... ☐ Survived ☐ Died

Died from this illness?..... Y ☐ N ☐ U

Location of death.....

☐ Home ☐ ER/ED

☐ Hospital ICU ☐ Hospital Inpatient

☐ En route to Hospital ☐ Long term care facility

☐ Other, specify

☐ Unknown

Patient died in NC..... ☐ Y ☐ N ☐ U

County of death .....

Date of death (mm/dd/yyyy):..... __/__/__

CONGREGATE LIVING

In the 14 days prior to illness onset, did the patient live in any congregate living facilities or stay in any other congregate living locations that were not their primary residence? (Add new for all that apply) ..... ☐ Y ☐ N ☐ U

☐ Correctional facility ☐ Barracks

☐ Shelter ☐ Commune

☐ Boarding School ☐ Camp

☐ Sorority/Fraternity ☐ University/College Residence Hall

☐ Assisted Living Facility/Long Term Care Facility

☐ Skilled Nursing Facility

☐ Other, specify:

Name of facility:

Start date: __/__/__

End date: __/__/__

Additional Congregate risk info:

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias

Birthdate (mm/dd/yyyy): / /	SSN:

HEALTH CARE FACILITY RISKS

In the 14 days prior to illness onset, did the patient have any of the following heath care exposures? (select all that apply)

☐ Emergency Department (not hospitalized)…….. ☐ Y ☐ N ☐ U
Visit / admit date (mm/dd/yyyy): __/__/__
Facility name:

☐ Hospitalized
Visit / admit date (mm/dd/yyyy): __/__/__
Discharge date (mm/dd/yyyy): __/__/__
Facility name:

☐ Outpatient facility – patient (e.g. urgent care, clinic, physician office)
Visit / admit date (mm/dd/yyyy): __/__/__
Facility name:

☐ Visitor to health care setting
Visit date (mm/dd/yyyy):……. __/__/__
Facility name:

☐ Worked in health care or clinical laboratory setting
Facility name:
What is their occupation:
☐ Physician ☐ Respiratory Therapist
☐ Nurse ☐ Environmental Services
☐ Other, specify
☐ Unknown

What is their job setting:
☐ Hospital ☐ Rehabilitation facility
☐ Assisted Living Facility/Long Term Care Facility
☐ Skilled Nursing Facility ☐ Unknown
☐ Other, specify

☐ No Known Exposure
☐ Other, please specify:

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms?..... ……..☐ Y ☐ N ☐ U
If yes, specify:

In the 14 days prior to illness onset, did the patient have contact with a known COVID-19 case (probable or confirmed)?.....☐ Y ☐ N ☐ U

If the patient had contact with a known COVID-19 case:
What type of contact?
☐ Household contact ☐ Community-associated contact
☐ Work-associated contact (**If you are a healthcare worker and you have contact with a co-worker with COVID-19, the exposure type is "Work-associated")
☐ Healthcare-associated contact (patient, visitor, or healthcare worker)
☐ Other, specify ☐ Unknown

In the 14 days prior to illness onset, did the patient have any of the following additional risk exposures? (check all that apply)

☐ Restaurant or other food establishment ☐ Indoor dine in ☐ Outdoor dine in ☐ Take out Name of restaurant:	☐ Community event/mass gathering; eg Concert, sporting event Specify type of event/gathering: Specify location of event/gathering:	☐ Processing Plant Specify name:
☐ Place of Worship Specify name:	☐ Adult Day Care/PACE program Specify name:	☐ Manufacturing Plant Specify name:
☐ Sports Team Participation Specify team/affiliation: Specify type of sport:	☐ Animal with confirmed or suspected COVID-19	☐ Day Camp Specify name:
☐ Pool or spa Specify name:	☐ Bars, breweries, or nightclubs ☐ Indoor ☐ Outdoor Specify name:	☐ Work (if any of these selected risks are work, please ensure work is also selected) Occupation: Employer Name: Business/Industry:
☐ Personal Care; eg Hair salon, massage Specify name:	☐ Indoor Entertainment; eg Bowling alley, movie theatre, arcade Specify name:	
☐ Hotel / motel Specify name:	☐ Gyms or fitness centers ☐ Indoor ☐ Outdoor Specify name:	
☐ Social gathering; eg B-day party, funeral Specify type of gathering:	☐ Other, specify:	☐ Unknown

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed?.....☐ Y ☐ N ☐ U
Interviewer's name
Date of interview (mm/dd/yyyy): __/__/__

If no, reason why the patient was not interviewed?
☐ Lost to follow-up (3 contact attempts made) ☐ Refused
☐ Pt unable to communicate ☐ Pt deceased ☐ Other, specify

Were interviews conducted with others?.....☐ Y ☐ N ☐ U
Who was interviewed? ☐ Employer/supervisor/co-worker ☐ Friend/neighbor ☐ Guardian ☐ Household contact/roommate ☐ Parent ☐ Other, specify
Date of interview (mm/dd/yyyy): __/__/__ Interviewer's name:

Did the patient or other interviewed name any contacts?...☐ Y ☐ N ☐ U
Number of contacts named:
If no, Reason no contacts named:
☐ No known contacts ☐ Pt/other refused ☐ Pt mentally incapacitated
☐ Contacts identified by facility ☐ Other, specify:

*Infectious period starts 48 hours prior to symptom onset or specimen collection date if asymptomatic

OPTIONAL: Add available Names/Locating info (phone, email, address) for close contacts during case-patient's infectious period

Were health care providers consulted?..... ☐ Y ☐ N ☐ U
Who was consulted? ☐ Infectious Disease Phys ☐ PA/FNP ☐ Physician ☐ Other, specify:
Name: Phone: ( ) -

Medical records reviewed (incl telephone review with provider/office staff)?..... ☐ Y ☐ N ☐ U

Specify reason medical records were not reviewed / other medical record notes:

Has this person received a COVID-19 vaccine? ☐ Y ☐ N ☐ U

Notes on vaccination