



Interim reporting form for suspected cases of 2019 Novel Coronavirus (2019-nCoV) (based on WHO Minimum Data Set Report Form)

Date of reporting to national health authority: [_] [_] / [_] [_] / [_] [_] [_] [_]

Reporting institution: _____

Detected at point of entry No Yes Unknown If yes, date [_] [_] / [_] [_] / [_] [_] [_] [_]

Section 1: Patient information

Unique case identifier (used at HF): _____

Date of birth: [_] [_] / [_] [_] / [_] [_] [_] [_] or estimated age: [] [] in years

if < 1 year, [] [] in months or if < 1 month, [] [] in days

Sex at birth: Male Female

Patients' usual place of residency: Country: _____

Admin Level 1 (province): _____ Admin Level 2 (district): _____

Section 2: Clinical information

Patient clinical course

Date of onset of symptoms: [_] [_] / [_] [_] / [_] [_] [_] [_]

Admission to hospital: No Yes

First date of admission to hospital: [_] [_] / [_] [_] / [_] [_] [_] [_]

Name of hospital: _____

Date of isolation: [_] [_] / [_] [_] / [_] [_] [_] [_]

Is the patient ventilated: No Yes Unknown

Date of death, if applicable: [_] [_] / [_] [_] / [_] [_] [_] [_]

Patient symptoms (check all reported symptoms):

- | | | |
|--|---|--|
| <input type="checkbox"/> History of fever / chills | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pain (check all that apply) |
| <input type="checkbox"/> General weakness | <input type="checkbox"/> Diarrhoea | () Muscular () Chest |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Nausea/vomiting | () Abdominal () Joint |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Headache | |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Irritability/Confusion | |
| <input type="checkbox"/> Other, specify _____ | | |

Patient signs :

Temperature: [] [] [] °C / F

Check all observed signs:

- | | | |
|---|---|---|
| <input type="checkbox"/> Pharyngea exudate | <input type="checkbox"/> Coma | <input type="checkbox"/> Abnormal lung x-ray findings |
| <input type="checkbox"/> Conjunctival injection | <input type="checkbox"/> Dyspnea / tachypnea | |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Abnormal lung auscultation | |
| <input type="checkbox"/> Other, specify _____ | | |

Underlying conditions and comorbidity (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Pregnancy (trimester: _____) | <input type="checkbox"/> Post-partum (<6 weeks) |
| <input type="checkbox"/> Cardiovascular disease, including hypertension | <input type="checkbox"/> Immunodeficiency, including HIV |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Renal disease |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Chronic lung disease |
| <input type="checkbox"/> Chronic neurological or neuromuscular disease | <input type="checkbox"/> Malignancy |
| <input type="checkbox"/> Other, specify _____ | |

Section 3: Exposure and travel information in the 14 days prior to symptom onset (prior to reporting if asymptomatic)

Occupation: (tick any that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Student | <input type="checkbox"/> Health care worker | <input type="checkbox"/> Other, specify: _____ |
| <input type="checkbox"/> Working with animals | <input type="checkbox"/> Health laboratory worker | |

Has the patient **travelled** in the 14 days prior to symptom onset? No Yes Unknown

If yes, please specify the places the patient travelled:

	Country	City
1.	_____	_____
2.	_____	_____
3.	_____	_____

Has the patient visited any health care facility(ies) in the 14 days prior to symptom onset? No Yes Unknown

Has the patient had **close contact**¹ with a person with acute respiratory infection in the 14 days prior to symptom onset?

If yes, contact setting (check all that apply):

- Health care setting Family setting Work place Unknown Other, specify: _____

Has the patient **had contact with a probable or confirmed case** in the 14 days prior to symptom onset?

- No Yes Unknown

If yes, please list unique case identifiers of all probable or confirmed cases:

Case 1 identifier. _____ Case 2 identifier. _____ Case 3 identifier. _____

If yes, contact setting (check all that apply):

- Health care setting Family setting Work place Unknown Other, specify: _____

If yes, location/city/country for exposure: _____

Have you visited any **live animal markets** in the 14 days prior to symptom onset? No Yes Unknown

If yes, location/city/country for exposure: _____

¹ Close contact' is defined as: 1. Health care associated exposure, including providing direct care for nCoV patients, working with health care workers infected with novel coronavirus, visiting patients or staying in the same close environment of a nCoV patient. 2. Working together in close proximity or sharing the same classroom environment with a with nCoV patient. 3. Traveling together with nCoV patient in any kind of conveyance. 4. Living in the same household as a nCoV patient

Section 4: Laboratory information

Samples collected		Date of Sample Collection (DD/MM/YYYY)	Date of Sample Sent (DD/MM/YYYY)
Nasopharyngeal	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Oropharyngeal (Throat)	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Sputum	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Endotracheal Aspirate	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Bronchioalveolar	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Serum	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Others	<input type="checkbox"/> No <input type="checkbox"/> Yes		

If Other samples collected, specify _____

Sample sent to

NIC/NPHL Others If others, specify _____

Any test conducted at HF / other laboratory for detection of pan-CoV

No Yes

If yes, please specify :

Details of test: _____

Name of the laboratory conducted: _____

Test results: _____