Patterns of Virus Exposure and Presumed Household Transmission among Persons with Coronavirus Disease, United States, January–April 2020

Appendix 1

COVID-19 Case Investigation Form

Reporting jurisdiction: ______________  Case state/local ID: ______________

Reporting health department: ______________  CDC 2019-nCoV ID: ______________

Contact ID a: ______________  NNDSS loc. rec. ID/Case ID b: ______________

a. Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case CA102034567 has contacts CA102034567 -01 and CA102034567 -02. b. For NNDSS reporters, use GenV2 or NETSS patient identifier.
**Interviewer information**

Name of interviewer: Last
First
Affiliation/Organization:
Telephone Email

Date of interview: (MM/DD/YYYY) Date of medical chart abstraction: (MM/DD/YYYY)

Data sources used for this form?
- [ ] Case-patient interview
- [ ] Other interview, specify relationship to case:
- [ ] Medical Chart Abstraction

Case-patient’s primary language: Was this form administered via a translator? [ ] Yes [ ] No [ ] Unknown

**Case-patient demographic information**

1. Report date to CDC (MM/DD/YYYY): ___/___/_____

2. Under what process was the case first identified? (check all that apply):
   - [ ] PUI/sought care for acute illness
   - [ ] Contact tracing of case patient
   - [ ] Surveillance system, please specify:
   - [ ] EpiX notification of travelers; if checked, DGMQID
   - [ ] Unknown
   - [ ] Other, specify:

3. Date of birth (MM/DD/YYYY): ___/___/_____

4. Age: _______ Age units: [ ] Years [ ] Months [ ] Days

5. Sex: [ ] Male [ ] Female [ ] Other [ ] Unknown

6. Ethnicity: [ ] Hispanic/Latino [ ] Non-Hispanic/Latino [ ] Not specified

7. Race (check all that apply):
   - [ ] White
   - [ ] Asian
   - [ ] American Indian/Alaska Native
   - [ ] Black
   - [ ] Native Hawaiian/Other Pacific Islander
   - [ ] Unknown
   - [ ] Other, specify:

8. County of Residence: State of Residence:_____

9. Country of Residence: [ ] United States [ ] Other, specify_________________

10. Occupation:__________________________________________
    If student, what grade level? __________________________________________
    If child, does s/he attend day care? [ ] Yes [ ] No [ ] Unknown

**Travel history**

11. In the 14 days prior to illness onset, were you traveling away from your home internationally? [ ] Yes [ ] No [ ] Unknown
12. In the 14 days prior to illness onset, were you traveling away from your home within the United States?
   □ Yes  □ No  □ Unknown
13. Where did you travel 14 days prior to illness onset (list ALL locations, including overnight transits and layovers)?

<table>
<thead>
<tr>
<th>Trip</th>
<th>Departure Date (MM/DD/YYYY)</th>
<th>Departure city, state/province/country</th>
<th>Arrival Date (MM/DD/YYYY)</th>
<th>Arrival city, state/province/country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trip 1</td>
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<td>Trip 2</td>
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<td>Trip 3</td>
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<td>Trip 4</td>
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<tr>
<td>Trip 5</td>
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</tr>
</tbody>
</table>

Exposure history
14. In the 14 DAYS prior to illness, did you have close contact with another lab-confirmed COVID-19 case-patient?
   □ Yes  □ No  □ Unknown   Date Range: Start Date (MM/DD/YYYY) ____________
   End Date (MM/DD/YYYY) ____________

15. Relationship to COVID-19 source case (select all that apply):
   □ Spouse/Partner □ Child □ Parent □ Other Family □ Friend □ HCW □ Co-worker
   □ Classmate □ Roommate □ Contact only – no relationship □ Other
   (specify): ______________________

16. Exposure setting to the COVID-19 source case (select all that apply):
   □ Household □ Work □ Daycare □ School/University □ Transit □ Rideshare □ Hotel □ Cruise Ship
   □ Healthcare □ Other (specify): ______________________

17. In the 14 DAYS prior to illness onset, did you:

<table>
<thead>
<tr>
<th>Exposure</th>
<th>Answer</th>
<th>Date Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>...have any household members, friends, acquaintances, or co-workers who had fever or respiratory symptoms (e.g. cough, sore throat etc.)?</td>
<td>□ Yes □ No □ Unknown</td>
<td></td>
</tr>
<tr>
<td>...have close contact (e.g. caring for, speaking with, or touching) with any ill persons?</td>
<td>□ Yes □ No □ Unknown</td>
<td></td>
</tr>
</tbody>
</table>
...attend a mass gathering (e.g., religious event, wedding, party, dance, concert, banquet, festival, sports event, or other event)?

- [ ] Yes
- [ ] No
- [ ] Unknown

...use public transportation (bus, train, airplane)?

- [ ] Yes
- [ ] No
- [ ] Unknown

...attend or work at a school or daycare?

- [ ] Yes
- [ ] No
- [ ] Unknown

...have a household member who attended school or daycare?

- [ ] Yes
- [ ] No
- [ ] Unknown

...have close contact (e.g. caring for, speaking with, or touching) with a sick person who had contact with a COVID-19 patient (i.e., secondary contact to confirmed case)?

- [ ] Yes
- [ ] No
- [ ] Unknown

...have close contact (e.g. caring for, speaking with, or touching) with a person who had a fever and/or acute respiratory illness and international travel in the past 2 weeks?

- [ ] Yes
- [ ] No
- [ ] Unknown

If yes where did the person travel: ______________________

---

18. In the **14 DAYS prior to illness onset**, did you:

<table>
<thead>
<tr>
<th>Exposure</th>
<th>Y/N/Unk</th>
<th>Facility type (Select all that apply)</th>
<th>Date(s) exposure occurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work in healthcare setting:</td>
<td>□ Y □ N □ Unk If yes, what was your role:</td>
<td>□ Hospital</td>
<td>□ Dialysis unit/center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Physician</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>□ Nurse</td>
<td>□ Long Term Care Facility</td>
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<td></td>
<td></td>
<td>□ Administration staff</td>
<td></td>
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<td></td>
<td></td>
<td>□ Housekeeping</td>
<td>□ Other (specify)</td>
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<td></td>
<td></td>
<td>□ Patient transport</td>
<td></td>
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<td></td>
<td></td>
<td>□ Other, specify</td>
<td></td>
</tr>
<tr>
<td>Volunteer in healthcare setting</td>
<td>□ Y □ N □ Unk</td>
<td>□ Hospital</td>
<td>□ Dialysis unit/center</td>
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<tr>
<td></td>
<td></td>
<td>□ Urgent Care</td>
<td>□ Long Term Care Facility</td>
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<tr>
<td></td>
<td></td>
<td>□ Doctor’s office/clinic</td>
<td>□ Other (specify)</td>
</tr>
<tr>
<td>Have direct patient contact</td>
<td>□ Y □ N □ Unk</td>
<td>□ Hospital</td>
<td>□ Dialysis unit/center</td>
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<tr>
<td></td>
<td></td>
<td>□ Urgent Care</td>
<td>□ Long Term Care Facility</td>
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<tr>
<td></td>
<td></td>
<td>□ Doctor’s office/clinic</td>
<td>□ Other (specify)</td>
</tr>
</tbody>
</table>
19. Do you reside in an institutional or group setting (e.g. long-term care facility/nursing home, boarding school, college dormitory, etc.)?  
☐ Yes  ☐ No  ☐ Unknown

20. How many people in total resided in your household (HH) from the 14 days prior to illness through the date of this interview (excluding you)? _______. A household member is anyone with at least one overnight stay during the 14 days prior to patient’s illness onset to the date of this interview. If patient belongs to multiple HH, group HH members by identifying the 1st HH as A, the 2nd HH as B, etc.

<table>
<thead>
<tr>
<th>HH (if case-patient belongs to &gt;1 HH)</th>
<th>Relation to patient</th>
<th>Sex M/F</th>
<th>Age (specify unit as years, months, or days)</th>
<th>Did household member have fever or respiratory symptoms (e.g. cough, sore throat, etc.) in the 14 days prior to patient’s illness onset, during the patient’s illness, or 14 days after patient’s illness?</th>
<th>Date of illness onset of household member (MM/DD/YYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ A ☐ B ☐ C</td>
<td>☐ Y ☐ N ☐ Unk</td>
<td></td>
<td>☐ Y ☐ N ☐ Unk</td>
<td>☐ Y ☐ N ☐ Unk</td>
<td>☐ Y ☐ N ☐ Unk</td>
</tr>
<tr>
<td>☐ A ☐ B ☐ C</td>
<td>☐ Y ☐ N ☐ Unk</td>
<td></td>
<td>☐ Y ☐ N ☐ Unk</td>
<td>☐ Y ☐ N ☐ Unk</td>
<td>☐ Y ☐ N ☐ Unk</td>
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<tr>
<td>☐ A ☐ B ☐ C</td>
<td>☐ Y ☐ N ☐ Unk</td>
<td></td>
<td>☐ Y ☐ N ☐ Unk</td>
<td>☐ Y ☐ N ☐ Unk</td>
<td>☐ Y ☐ N ☐ Unk</td>
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<tr>
<td>☐ A ☐ B ☐ C</td>
<td>☐ Y ☐ N ☐ Unk</td>
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<td>☐ Y ☐ N ☐ Unk</td>
<td>☐ Y ☐ N ☐ Unk</td>
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<tr>
<td>☐ A ☐ B ☐ C</td>
<td>☐ Y ☐ N ☐ Unk</td>
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<td>☐ Y ☐ N ☐ Unk</td>
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<tr>
<td>☐ A ☐ B ☐ C</td>
<td>☐ Y ☐ N ☐ Unk</td>
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<td>☐ Y ☐ N ☐ Unk</td>
<td>☐ Y ☐ N ☐ Unk</td>
<td>☐ Y ☐ N ☐ Unk</td>
</tr>
</tbody>
</table>
Symptoms

21. If symptomatic, onset date of first symptom (MM/DD/YYYY): ____/_____/_______
   Unknown □  Asymptomatic

22. If experienced symptoms, are you □ Still symptomatic  □ Unknown symptom status  □
   Symptoms resolved
   If symptoms resolved, date of symptom resolution (MM/DD/YYYY): ____/_____/_____
   Unknown date

23. During this illness, did you experience any of the following symptoms?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
<th>Unk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever ≥100.4F (38C)</td>
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<tr>
<td>Highest temp _____ °F</td>
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<tr>
<td>Cough (new onset or worsening of chronic cough)</td>
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<tr>
<td>Date of onset (MM/DD/YYYY)</td>
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<tr>
<td>Productive</td>
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<tr>
<td>Duration of fever ≥100.4F (38C) (days)</td>
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<tr>
<td>Bloody sputum (hemoptysis)</td>
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<tr>
<td>Subjective fever (felt feverish)</td>
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<tr>
<td>Chills</td>
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<tr>
<td>Fatigue</td>
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<tr>
<td>Muscle aches (myalgia)</td>
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<tr>
<td>Rash</td>
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<td>Headache</td>
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<tr>
<td>Eye redness (conjunctivitis)</td>
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<tr>
<td>Runny nose (rhinorrhea)</td>
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<td>Sore throat</td>
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<td>Other, specify:</td>
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<tr>
<td>Subjective fever (felt feverish)</td>
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<tr>
<td>Cough (new onset or worsening of chronic cough)</td>
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<tr>
<td>Date of onset (MM/DD/YYYY)</td>
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<tr>
<td>Productive</td>
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<tr>
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<td>Subjective fever (felt feverish)</td>
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<tr>
<td>Chills</td>
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<tr>
<td>Fatigue</td>
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<tr>
<td>Muscle aches (myalgia)</td>
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<tr>
<td>Rash</td>
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<td>Runny nose (rhinorrhea)</td>
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<tr>
<td>Sore throat</td>
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<tr>
<td>Other, specify:</td>
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<tr>
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<td>Cough (new onset or worsening of chronic cough)</td>
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<td>Date of onset (MM/DD/YYYY)</td>
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<tr>
<td>Productive</td>
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<tr>
<td>Duration of fever ≥100.4F (38C) (days)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Bloody sputum (hemoptysis)</td>
<td></td>
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</tbody>
</table>

Past medical history

24. Do you have any pre-existing medical conditions? □ Yes □ No □ Unknown

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Lung Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma/reactive airway disease</td>
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<td></td>
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<tr>
<td>Emphysema/COPD</td>
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<td></td>
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<tr>
<td>Other chronic lung disease</td>
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<tr>
<td>Active tuberculosis</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

(If YES, specify)
<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Mellitus</td>
<td></td>
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<tr>
<td>Cardiovascular disease</td>
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<tr>
<td>Hypertension</td>
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<tr>
<td>Coronary artery disease</td>
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<tr>
<td>Heart failure/Congestive heart failure</td>
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<tr>
<td>Cerebrovascular accident/Stroke</td>
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<tr>
<td>Congenital heart disease</td>
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<td></td>
<td></td>
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<tr>
<td>Other</td>
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<td></td>
<td>Unknown</td>
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<tr>
<td>Renal disease</td>
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<td></td>
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<tr>
<td>Chronic kidney disease/insufficiency</td>
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<tr>
<td>End-stage renal disease</td>
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<td></td>
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<tr>
<td>Dialysis</td>
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<td></td>
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<tr>
<td>Other</td>
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<td></td>
<td>Unknown</td>
</tr>
<tr>
<td>Liver disease</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Alcoholic hepatitis</td>
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<td></td>
<td></td>
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<tr>
<td>Chronic liver disease</td>
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<tr>
<td>Cirrhosis/End stage liver disease</td>
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<tr>
<td>Hepatitis B, chronic</td>
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<tr>
<td>Hepatitis C, chronic</td>
<td></td>
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<tr>
<td>Non-alcoholic fatty liver disease (NAFLD)/NASH</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
<td>Unknown</td>
</tr>
<tr>
<td>Immuneocompromised Condition</td>
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<tr>
<td>HIV infection</td>
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<tr>
<td>AIDS or CD4 count &lt;200</td>
<td></td>
<td></td>
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<tr>
<td>Solid organ transplant</td>
<td></td>
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<tr>
<td>Stem cell transplant (e.g., bone marrow transplant)</td>
<td></td>
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<tr>
<td>Cancer: current/in treatment or diagnosed in last 12 months</td>
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<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
<td>Unknown</td>
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<tr>
<td>Immunosuppressive therapy</td>
<td></td>
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</tr>
</tbody>
</table>

If YES, specify: ________________________________
For what condition: 

______________________________

Neurologic/neurodevelopmental disorder  □ Yes □ No □ Unknown  
If YES, specify:

Other chronic diseases  □ Yes □ No □ Unknown  
If YES, specify:

25. Current height: _________ (inches)  OR __________ (cm)
26. Current weight: _________ (pounds)  OR __________ (kg)
27. If female, are you currently pregnant?  □ Yes  Weeks pregnant at illness onset__________  
□ No  □ Unknown
28. If female, are you postpartum (≤6 weeks postpartum)?  □ Yes □ No  □ Unknown
29. If female, are you breastfeeding?  □ Yes □ No  □ Unknown
30. If child, is he/she being breastfed?  □ Yes □ No  □ Unknown

Social history
31. Do you currently smoke cigarettes?  □ Yes □ No □ Unknown
   If yes, how many packs of cigarettes per day? ______ For how many years? ______
32. Have you ever smoked cigarettes?  □ Yes □ No □ Unknown
   If yes, how many packs of cigarettes per day? ______ For how many years? ______ How long since you last smoked a cigarette? _m_ (y)
33. Do you currently use e-cigarettes/vape-pen?  □ Yes □ No □ Unknown
34. In the past year, how often did you have a drink containing alcohol?
   □ Never □ Monthly or less □ 2-4 times a month □ 2-3 times per week □ 4 or more times per week

Course of Illness
35. Do you feel back to normal?  □ Yes □ No  □ Not applicable (patient deceased) □ Not applicable (patient asymptomatic) □ Unknown
   If yes, when did you feel back to normal? _____/_____/_______ (MM/DD/YYYY)
36. Did you miss work or school for this illness?  □ Yes □ No □ Unknown
   If yes, how many days during illness? __________
37. Did you receive any medical care for the illness?  □ Yes □ No □ Unknown
38. If yes, where and which dates did you seek care after this illness started (check all that apply)? [Please add extra visit dates in comments box]
   □ Doctor’s office Date 1: _____/_____/_______ (MM/DD/YYYY) Date 2: _____/_____/_______ (MM/DD/YYYY)
   □ Emergency room Date 1: _____/_____/_______ (MM/DD/YYYY) Date 2: _____/_____/_______ (MM/DD/YYYY)
   □ Retail store/pharmacy Date 1: _____/_____/_______ (MM/DD/YYYY) Date 2: _____/_____/_______ (MM/DD/YYYY)
39. Was the patient hospitalized? □ Yes □ No □ Unknown  **If YES, please fill out hospitalization section below If no, skip to Question #53**

Purpose: □ Clinical indication □ No clinical indication (e.g., isolation for public health)

**Hospitalization**

40. Hospital name: ____________________________________________ Hospital phone: _____________________________

41. If yes, Admission date 1 ___/___/___ (MM/DD/YYYY) , discharge date 1 ___/___/___ (MM/DD/YYYY) □ Patient still hospitalized

42. To where was the patient discharged?
   □ Home □ Transferred to another hospital □ Nursing facility/rehab □ Hospice
   □ Other ______________ □ Unknown

43. If hospitalized more than once, please enter the second hospitalization’s admission and discharge dates:
   Hospital name: ____________________________________________ Hospital phone: _____________________________
   Admission date 2 ___/___/___ (MM/DD/YYYY) Discharge date 2 ___/___/___ (MM/DD/YYYY)
   □ Patient still hospitalized

44. To where was the patient discharged?
   □ Home □ Transferred to another hospital □ Nursing facility/rehab □ Hospice
   □ Other ______________ □ Unknown

45. First recorded vital signs: Temp_________ (Unit: □ °F / □ °C)  Blood pressure:
   _______ (systolic) / _______ (diastolic)
   Heart rate: _______  Resp rate:___________
   O2 Sat: _______________ (Type of support required when O2 saturation was measured:
   □ Room Air □ Nasal Cannula □ Face Mask □ CPAP or BIPAP □ High Flow Nasal Cannula
   □ Invasive mechanical ventilation
   □ Other, specify: □ Unknown
   Fraction of Inspired Oxygen/Flow ___________% □ Liters/minute (LPM) □ Unknown
   □ NA
46. First recorded laboratory values for:

<table>
<thead>
<tr>
<th></th>
<th>Date (MM/DD/YYYY)</th>
<th>Value</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>White blood cell (WBC) count</td>
<td></td>
<td></td>
<td>Cells x 109/L □</td>
</tr>
<tr>
<td>Absolute neutrophil count</td>
<td></td>
<td></td>
<td>Cells x 109/L □</td>
</tr>
<tr>
<td>Absolute lymphocyte count</td>
<td></td>
<td></td>
<td>Cells x 109/L □</td>
</tr>
<tr>
<td>Platelets (Plt)</td>
<td></td>
<td></td>
<td>Cells x 109/L □</td>
</tr>
<tr>
<td>Aspartate transaminase (AST)</td>
<td></td>
<td></td>
<td>U/L □</td>
</tr>
<tr>
<td>Alanine aminotransferase (ALT)</td>
<td></td>
<td></td>
<td>U/L □</td>
</tr>
<tr>
<td>Lactate dehydrogenase (LDH)</td>
<td></td>
<td></td>
<td>U/L □</td>
</tr>
</tbody>
</table>

47. Was the patient admitted to an intensive care unit (ICU)? □ Yes □ No □ Unknown

ICU admission date 1 ______/_____/_______ (MM/DD/YYYY) ICU admission date 2 ______/_____/_______ (MM/DD/YYYY)
ICU discharge date 1 ______/_____/_______ (MM/DD/YYYY) ICU discharge date 2 ______/_____/_______ (MM/DD/YYYY)

48. During hospitalization, did the patient receive...

<table>
<thead>
<tr>
<th></th>
<th>Start Date (MM/DD/YYYY)</th>
<th>Last Date (MM/DD/YYYY)</th>
<th>Total Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental Oxygen?</td>
<td>□ Y □ N □ Unk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BiPap or CPAP use?</td>
<td>□ Y □ N □ Unk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High flow nasal cannula?</td>
<td>□ Y □ N □ Unk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invasive mechanical ventilation?</td>
<td>□ Y □ N □ Unk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ECMO?</td>
<td>□ Y □ N □ Unk</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

49. Did the patient receive a discharge diagnosis of pneumonia (refer to clinical discharge summary)? □ Yes □ No □ Unknown
50. Did the patient receive a discharge diagnosis of acute respiratory distress syndrome (ARDS) (refer to clinical discharge summary)?

☐ Yes  ☐ No  ☐ Unknown

51. Clinical Discharge Diagnoses and ICD10 Discharge Codes

<table>
<thead>
<tr>
<th>Clinical Discharge Diagnoses</th>
<th>ICD-10-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
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<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
</tr>
</tbody>
</table>

52. Did the patient receive any antiviral medications during hospitalization for this illness:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Start Date (MM/DD/YYYY)</th>
<th>Last Date (MM/DD/YYYY)</th>
<th>Total Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remdesivir</td>
<td>□ PO</td>
<td>□ IV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ IM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: _______________</td>
<td>□ PO</td>
<td>□ IV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ IM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: _______________</td>
<td>□ PO</td>
<td>□ IV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ IM</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Imaging

53. Was a chest x-ray taken?  ☐ Yes  ☐ No  ☐ Unknown

54. Were any of these chest x-rays abnormal?  ☐ Yes  ☐ No  ☐ Unknown

Date of first abnormal chest x-ray: _____/_____/_______ (MM/DD/YYYY)

55. For first abnormal chest x-ray, please check all that apply:

- ☐ Air space density
- ☐ Cannot rule out pneumonia
- ☐ ARDS (acute respiratory distress syndrome)
- ☐ Other
- ☐ Air space opacity
- ☐ Consolidation
- ☐ Lung infiltrate
- ☐ Pleural Effusion
- ☐ Bronchopneumonia/pneumonia
- ☐ Cavitation
- ☐ Interstitial infiltrate
- ☐ Empyema

56. Was a chest CT/MRI taken?  ☐ Yes  ☐ No  ☐ Unknown
57. Were any of these chest CT/MRIs abnormal?  
☐ Yes  ☐ No  ☐ Unknown  
Date of first abnormal CT/MRI: ______/_____/_______ (MM/DD/YYYY)

58. For first abnormal chest CT/MRI, please check all that apply:  
☐ Report not available:  
☐ Air space density  ☑ ARDS (acute respiratory distress syndrome)  ☐ Empyema  ☐ Enlarge epiglottis  
☐ Air space opacity/opacification  ☐ Lung infiltrate  ☐ Pneumothorax  ☐ Tracheal narrowing  
☐ Bronchopneumonia/pneumonia  ☐ Interstitial infiltrate  ☐ Pneumomediastinum  ☐ Ground glass opacities  
☐ Consolidation  ☐ Lobar infiltrate  ☐ Widened mediastinum  ☐ Other  
☐ Cavitation  ☐ Pleural effusion  

Lab Results
59. SARS-CoV-2 Testing (Please report further test results in comments)  

<table>
<thead>
<tr>
<th>Date of sample collection (MM/DD/YYYY)</th>
<th>Sample Type</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ NP ☐ OP ☐ Sputum ☐ Other, specify:</td>
<td>☐ Pos ☐ Neg ☐ Inconclusive</td>
</tr>
<tr>
<td></td>
<td>☐ NP ☐ OP ☐ Sputum ☐ Other, specify:</td>
<td>☐ Pos ☐ Neg ☐ Inconclusive</td>
</tr>
<tr>
<td></td>
<td>☐ NP ☐ OP ☐ Sputum ☐ Other, specify:</td>
<td>☐ Pos ☐ Neg ☐ Inconclusive</td>
</tr>
<tr>
<td></td>
<td>☐ NP ☐ OP ☐ Sputum ☐ Other, specify:</td>
<td>☐ Pos ☐ Neg ☐ Inconclusive</td>
</tr>
</tbody>
</table>

60. Was patient tested for other viral respiratory pathogens during their illness?  
☐ Yes (report results below)  ☐ No  ☐ Unknown  

<table>
<thead>
<tr>
<th>Specimen Type</th>
<th>Positive</th>
<th>Negative</th>
<th>Not Tested/Unknown</th>
<th>Collection Date (MM/DD/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu A/H1</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td><strong><strong><strong>/</strong></strong><em>/</em></strong>____</td>
</tr>
<tr>
<td>Flu A/H3</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td><strong><strong><strong>/</strong></strong><em>/</em></strong>____</td>
</tr>
<tr>
<td>Flu B</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td><strong><strong><strong>/</strong></strong><em>/</em></strong>____</td>
</tr>
<tr>
<td>Flu (no type)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td><strong><strong><strong>/</strong></strong><em>/</em></strong>____</td>
</tr>
<tr>
<td>Virus</td>
<td><em>Yes</em></td>
<td><em>No</em></td>
<td><em>Unknown</em></td>
<td>Date (MM/DD/YYYY)</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------</td>
<td>------</td>
<td>-----------</td>
<td>------------------</td>
</tr>
<tr>
<td>Respiratory syncytial virus/RSV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adenovirus</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parainfluenza virus 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Parainfluenza virus 2</td>
<td></td>
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<tr>
<td>Parainfluenza virus 3</td>
<td></td>
<td></td>
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<tr>
<td>Parainfluenza virus 4</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory syncytial virus/RSV</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Human metapneumovirus</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Rhinovirus/enterovirus</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Human coronavirus 229E</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human coronavirus HKU1</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Human coronavirus NL63</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Human coronavirus OC43</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

61. Were any bacterial culture tests performed during their illness? ☐ Yes ☐ No ☐ Unknown
   If yes, was there a positive culture for a bacterial pathogen? ☐ Yes ☐ No ☐ Unknown
   If yes, specify pathogen: __________________________________________________
   If yes, specify date of culture (MM/DD/YYYY): ____________
   If yes, site where pathogen identified: ☐ Blood  ☐ Sputum  ☐ Bronchoalveolar lavage (BAL)  ☐ Endotracheal aspirate  ☐ Pleural fluid  ☐ Cerebrospinal fluid (CSF)  ☐ Other, specify: ________________
   If more than one bacterial culture test was performed, please record in additional comments.

Outcome

62. Did the patient die as a result of this illness? ☐ Yes, Date: ____/__/____ (MM/DD/YYYY) ☐ No ☐ Unknown
   Where did the death occur? ☐ Home  ☐ Hospital  ☐ ER  ☐ Hospice  ☐ Other, specify ________________
   (If the following information is not currently available, please send an update later using death certificate or death note in hospital record.)
   Contribution of COVID-19 to death ☐ Underlying/primary  ☐ Contributing/secondary  ☐ No contribution to death  ☐ Unknown
   Was autopsy performed? ☐ Yes ☐ No ☐ Unknown
Primary Cause of death (death certificate/coroner)

Any additional comments or notes?

This is the end of the case investigation form. Thank you very much for your time. If you have any questions please feel free to contact the CDC at 770-488-7100 or eocreport@cdc.gov