

COVID-19 CASE INVESTIGATION FORM

Reporting Centre: Private – **Kelso Medical Laboratory** Public Date of patient visit(dd/mm/yyyy) / /

Reporting health worker (PRINT IN BLOCKS)

1. Patient Information

Name	Age	Date of birth (dd/mm/yyyy) / /	Sex: M F
Address	Phone	Surveillance Unit (SU) #: Influenza vaccine: YIN	
Occupation:Place of employment: Is/was the patient a health care provider: YIN If es, where?			

2. Clinical Data

Date of onset of illness / /				Immunization history (most recent) Date of last dose (dd/mm/yyyy) / /	
Symptom	YIN	Symptom	YIN	Symptom	YIN
Fever		Headache		Sore throat	
Dry cough		Myalgia		Runny nose	
Shortness of breath		Cough		Sneezing	
Fatigue		Pneumonia		Itchy eyes	
Chills		Vomiting		Abd. Pain	
Diarrhoea		Other:			

Comorbid conditions: None Unknown Pregnancy Diabetes Hypertension Cardiac disease Pulmonary disease Kidney Liver disease Immunocompromised Other (specify)

Is/was the patient placed in home isolation? Y/N If yes, where?	Dates	Outcome of illness
Is/was the patient hospitalized? YIN If yes, where?		Survived YIN
		Discharged alive From home isolation: Date / / From hospital: Date / /
		Died:Date / /
Is/was the patient seen at a public or private health care facility outside of a hospital? YIN If es, where?	Dates	Additional comments:
Was there close contact with a case within the past 14 days? YIN If yes, where: Home (bedroom) <input type="checkbox"/> Home (household) <input type="checkbox"/> Work <input type="checkbox"/> Health Care Setting <input type="checkbox"/> Transportation <input type="checkbox"/> Casual <input type="checkbox"/> Other, please specify:	Dates	Additional comments:
Is there a cluster of similar cases in their neighborhood/work? YIN	Comment:	

3. Laboratory data

Specimen	Data collected	Date received (dd/mm/yyyy)	Condition (Adequate/ Inadequate/ Inconclusive)	Test (e.g. PCR)	Result (+ve, -ve, other)	Date of Result	Comment
Nasopharyngeal swab							
Oropharyngeal swab							
Acute blood							
Convalescent blood							

4. Final case classification

<input type="checkbox"/> Suspected <input type="checkbox"/> Epidemiologically confirmed <input type="checkbox"/> Laboratory confirmed <input type="checkbox"/> Laboratory negative	Date report completed (dd/mm/yyyy) / /
	To whom:
	Route: Phone: Email: WhatsApp:
	Signature:

