# COVID-19 CASE INVESTIGATION FORM

| Reporting Centre: [ **X**] Private – **Kelso Medical Laboratory** [ ] Public<br>Reporting health worker (PRINT IN BLOCKS) | Date of patient visit(dd/mm/yyyy)<br>/ / |
|---|---|

## 1. Patient Information

| Name | Age | Date of birth (dd/mm/yyyy)<br>/ / | Sex: M ☐ F ☐ |
|---|---|---|---|
| Address | Phone | | Surveillance Unit (SU) #:<br>Influenza vaccine: YIN |

Occupation:Place of employment:
Is/was the patient a health care provider: YIN If yes, where?

## 2. Clinical Data

| Date of onset of illness / / | Immunization history (most recent)<br>Date of last dose (dd/mm/yyyy)<br>/ / |
|---|---|

| Symptom | YIN | Symptom | YIN | Symptom | YIN | Additional comments: |
|---|---|---|---|---|---|---|
| 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<br>If yes, where?<br><br>Is/was the patient hospitalized? YIN<br>If yes, where? | Dates | **Outcome of illness**<br>Survived YIN<br>Discharged alive<br>From home isolation: Date / /<br>From hospital: Date / /<br>Died:Date / / |
|---|---|---|
| Is/was the patient seen at a public or private health care facility outside of a hospital? YIN<br>If es, where? | Dates | Additional comments: |
| Was there close contact with a case within the past 14 days? YIN<br>If yes, where: Home (bedroom) [ ] Home (household) [ ]Work [ ]<br>Health Care Setting [ ] Transportation [ ] Casual [ I 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

[ ] Suspected
[ ] Epidemiologically confirmed
[ ] Laboratory confirmed
[ ] Laboratory negative

Date report completed (dd/mm/yyyy) / /
To whom:
Route: Phone: Email: WhatsApp:
Signature:

ADDITIONAL NOTES MAY BE WRITTEN ON THIS OVERLEAF