COVID-19 CASE INVESTIGATION FORM

Reporting Centre: [**X**] Private – **Kelso Medical Laboratory** [ ] Public

Date of patient visit(dd/mm/yyyy) / /

Reporting health worker (PRINT IN BLOCKS)

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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:			

Additional comments:

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

	Dates	Outcome of illness
Is/was the patient placed in home isolation? Y/N If yes, where? 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) [ ] Home (household) [ ]Work [ ] 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:	

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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

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