Indicates information needed for chart abstraction

*Investigator Name: ___________________

*Investigation Start Date: _______________

Investigation End Date: _________________

DALLAS COUNTY HEALTH AND HUMAN SERVICES

DCHHS Case Report Form — Novel Coronavirus

State ID: __________________

NNDSS ID: __________________

*DCHHS ID: ________________

Note: Please include a copy of the lab report when submitting this completed Case Report Form.

PATIENT

*Last Name: | *First Name: | *MRN: , or ☐ records not received

*DOB: | *Age: | *Sex: ☐ M ☐ F | *Race: | *Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Residency: ☐ U.S. ☐ Non-U.S., country:_________________________ | Patient Phone:

Patient Email:

Occupation: ☐ Employed, occupation: _____________________________ ☐ Unemployed ☐ Student, School name: ___________________________

Employer Name and Address (☐ N/A):

*Home Address: | *City: | *State: | *County: | *Zip Code:

**Check that their address is in Dallas County by inputting it into this website: https://www.unitedstateszipcodes.org/*

ADMIN

Reporter Name: | Reporter Phone: | Reporter Email:

*Physician Name: | Physician/Facility Phone:

*Type of facility where care was sought: ☐ Hospital ☐ Outpatient facility ☐ Drive-thru testing facility ☐ ED only

*Hospital/Facility Name:

*RISK FACTORS

☐ Y ☐ N *Patient is a healthcare worker: Occupation: ____________________________ Facility/Employer Name: ___________________________

☐ Y ☐ N *Close contact of **(Check one):** ☐ Lab-confirmed COVID-19 case **or** ☐ Person with pneumonia or influenza-like illness
Name of Case: | Date of Last Contact: | Nature of Contact:

☐ Y ☐ N *Member of a cluster of patients with acute respiratory illness/pneumonia of unknown etiology in which COVID-19 is being evaluated

☐ Y ☐ N *History of being in a healthcare facility (as a patient or visitor): Facility name: ___________________________ Date Visited: __________

☐ Y ☐ N *Resident of long-term care facility or assisted living facility: Facility name: ____

☐ Y ☐ N *Underlying health conditions **(check)**: ☐ Asthma ☐ COPD ☐ Renal disease ☐ Immunocompromised ☐ Diabetes ☐ Other:________________

☐ Y ☐ N *Travel outside of Dallas County (international or domestic) or cruise within 2 weeks before illness onset:
Country/City/Cruise Name: _________________________________ *Arrival date:* ________________ *Departure Date:* _______________
*Country/City/Cruise Name:*_________________________________ *Arrival date:* ________________ *Departure Date:* _______________

Comments:

CLINICAL HISTORY

*Hospitalized? ☐ N ☐ Y | *Admit Date: | *Still hospitalized? ☐ Y ☐ N | ☐ Y ☐ N *ICU admission

*Discharge Date (☐ N/A) : | *Deceased Date (☐ N/A): | ☐ Y ☐ N *Mech. vent. (Bipap, intub., ____________)

*Discharged: ☐ N/A ☐ Home ☐ LTCF ☐ Other: | ☐ Y ☐ N * (Check if applies): ☐ ECMO ☐ ARDS

***Date symptom onset:** _________________, or ☐ Asymptomatic

Symptoms Resolved? ☐ No ☐ Yes, date: ___________________

Symptoms				Respiratory Diagnostic Testing	Date	Pos.	Neg.	Pend.	Not Done
				Influenza rapid Ag ☐ A ☐ B		☐ P	☐ N	☐ Pend.	☐ ND
Fever >100F (38C)	☐ Y	☐ N	☐ Unk	Rapid Strep		☐ P	☐ N	☐ Pend.	☐ ND
Subjective fever (felt feverish)	☐ Y	☐ N	☐ Unk	Influenza PCR ☐ A ☐ B		☐ P	☐ N	☐ Pend.	☐ ND
Cough (new or worsening of chronic cough)	☐ Y	☐ N	☐ Unk	RSV PCR		☐ P	☐ N	☐ Pend.	☐ ND
Shortness of breath (dyspnea)	☐ Y	☐ N	☐ Unk	H. metapneumovirus PCR		☐ P	☐ N	☐ Pend.	☐ ND
Chills	☐ Y	☐ N	☐ Unk	Parainfluenza (1-4) PCR		☐ P	☐ N	☐ Pend.	☐ ND
Muscle aches (myalgia)	☐ Y	☐ N	☐ Unk	Adenovirus PCR		☐ P	☐ N	☐ Pend.	☐ ND
Runny nose (rhinorrhea)	☐ Y	☐ N	☐ Unk	Rhinovirus/enterovirus PCR		☐ P	☐ N	☐ Pend.	☐ ND
Sore throat	☐ Y	☐ N	☐ Unk	Coronavirus (OC43, 229E, HKU1, NL63) PCR		☐ P	☐ N	☐ Pend.	☐ ND
Nausea of vomiting	☐ Y	☐ N	☐ Unk	*M. pneumoniae* PCR		☐ P	☐ N	☐ Pend.	☐ ND
Headache	☐ Y	☐ N	☐ Unk	*Legionella* Ur Ag		☐ P	☐ N	☐ Pend.	☐ ND
Abdominal pain	☐ Y	☐ N	☐ Unk	*S. pneumoniae* Ur Ag		☐ P	☐ N	☐ Pend.	☐ ND
Diarrhea (≥ 3/24hr period)	☐ Y	☐ N	☐ Unk	*C. pneumoniae*		☐ P	☐ N	☐ Pend.	☐ ND
Other, specify:	☐ Y	☐ N	☐ Unk	Other:		☐ P	☐ N	☐ Pend.	☐ ND

☐ Y ☐ N CHEST X-RAY | Date: | Results:

☐ Y ☐ N CHEST CT | Date: | Results:

Comments:

*TEST RESULTS

*Laboratory Name: | *Laboratory Type*: ☐ Commercial ☐ Hospital ☐ TX DSHS LRN Lab ☐ DSHS-Austin Lab

*Specimen Type	Specimen ID	*Date Collected	*Date Resulted	*SARS-CoV-2 Detected?
☐ NP ☐ OP ☐ Other: _____________				☐ Detected ☐ Not Detected ☐ Inconclusive

CALL ATTEMPTS: ☐ **Date:** _______________ ☐ **Date:** _______________ ☐ **Date:** _______________ ☐ **Lost to follow-up (Date:** ______________________**)**

☐ **Y** ☐ **N** **Patient interested in donating serum? If Yes, Email:** ____

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