

Case Investigation form: Request for 2019-nCoV Testing

Internal use
CRDM CIF no: _____
CRDM unique no: _____

Tel: (+27)3866392/ (+27) 3866410 | Fax: (+27)11 3868580 | Hotline: 082 883 9920 | E-mail: ncov@nicd.ac.za

Today's date: DD/MM/YYYY		Form completed by (Name, surname):		Contact number:	
Is this a: New clinical query <input type="checkbox"/>		Contact of a known case <input type="checkbox"/>		If contact of a known case, Known case fist name:	
		Known case surname:		Known case DOB: DD/MM/YYYY	
PATIENT DETAILS			DOCTOR'S DETAILS		
Patient hospital number (if available):			Name:		
First name:		Surname:		Surname:	
DOB: DD/MM/YYYY		Gender:		Contact number/s:	
Residency: SA resident <input type="checkbox"/> Non-SA resident <input type="checkbox"/> (specify) _____					
Current residential Address ¹ :					
Patient's contact number/s:					
NEXT OF KIN CONTACT DETAILS			Facility name:		
Relationship to the patient:		Contact number:		Email address:	
Date collected: DD/MM/YYYY		Date of symptom onset: DD/MM/YYYY			
Date of consultation/admission: DD/MM/YYYY					
Symptoms (tick all that apply) : Fever ($\geq 38^{\circ}\text{C}$) <input type="checkbox"/> Cough <input type="checkbox"/> Chills <input type="checkbox"/> Sore throat <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhoea <input type="checkbox"/>					
Myalgia/body pains <input type="checkbox"/> Other <input type="checkbox"/> (specify if other) _____					
<ul style="list-style-type: none"> • Diagnosis: Did the patient have clinical or radiological evidence of pneumonia? Y <input type="checkbox"/> N <input type="checkbox"/> • Were chest X-rays (CXR) done: Y <input type="checkbox"/> N <input type="checkbox"/> If yes, CXR Findings: _____ • Did the patient have clinical or radiological evidence of acute respiratory distress syndrome (ARDS)? Y <input type="checkbox"/> N <input type="checkbox"/> • Does the patient have another diagnosis/etiology for their respiratory illness? Y <input type="checkbox"/> (specify) _____ N <input type="checkbox"/> Unknown <input type="checkbox"/> 					
This section is a prerequisite for testing, therefore, please fill out the below section to the best of your ability. Laboratory testing will be delayed if forms are incomplete or were filled in incorrectly.					
In the 14 days before symptom onset did the patient (mark all that apply):					
<ul style="list-style-type: none"> • Have close physical contact² with a known 2019-nCoV case? Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> • Have close physical contact² with an ill traveler from China³ or other countries where 2019-nCoV is circulating or where human infections have recently occurred? Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> (if yes, complete section below for countries visited) • Patient is a healthcare worker? Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> • Patient is a healthcare worker who was exposed to patients with severe acute respiratory infections? Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> • Patient has visited a health care facility (as a patient or visitor) in China³ or in other countries where 2019-nCoV is circulating or where human infections have recently occurred? Y <input type="checkbox"/> N <input type="checkbox"/> (if yes, complete section below for countries visited) • Is the patient part of a severe respiratory illness cluster of unknown aetiology that occurred within a 14-day period? Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> • Has the patient travelled to/from Wuhan, China or in countries where 2019-nCoV is known to be circulating or where human infections have recently occurred? Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> (if any travel outside SA in the last 14-days, please complete section below for countries visited) 					
Country visited (Please specify the city travelled to)		Date of departure (travel to area)		Date of return (travel from area)	
1.		DD/MM/YYYY		DD/MM/YYYY	
2.		DD/MM/YYYY		DD/MM/YYYY	
Underlying factors/Co-morbid conditions			Treatment/management		
Asthma: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> Cardiac disease: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/>			Patient hospitalised: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> Admitted to ICU: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/>		
Chronic kidney disease: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> Chronic liver disease: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/>			Ventilation: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> On ECMO: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/>		
COPD/Chronic pulmonary disease: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> Diabetes: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/>			Tamiflu/other antiviral drugs: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/>		
HIV: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> Obesity: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> Pregnancy: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/>			Antibiotics: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> if Yes, list:		
Tuberculosis: Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> Other: Y <input type="checkbox"/> (specify): _____ Unknown: <input type="checkbox"/>			White cell count total:		Differential neutrophils/lymphocytes%:
Type of sample: Sputum <input type="checkbox"/> Bronchoalveolar lavage <input type="checkbox"/> Tracheal aspirate <input type="checkbox"/> Nasopharyngeal aspirate <input type="checkbox"/> Nasopharyngeal (NP)swab <input type="checkbox"/>					
Oropharyngeal (OP) swab <input type="checkbox"/> NP&OP swabs <input type="checkbox"/> Serum <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Other <input type="checkbox"/> (specify if other) _____					
Patient outcome		Discharged <input type="checkbox"/> Discharge date: DD/MM/YYYY Currently hospitalised: <input type="checkbox"/> Transferred <input type="checkbox"/> Name of facility _____			
		Died <input type="checkbox"/> Date of death: DD/MM/YYYY Other <input type="checkbox"/> (specify) _____			

¹If patient is a not a permanent resident, may you please provide their current residential address while residing in South Africa. ²Close contact is defined as: a) being within approximately 6 feet (2 meters) or within the room or care area for a prolonged period of time (e.g., healthcare personnel, household members) while not wearing recommended personal protective equipment (i.e. gloves, respirator, eye protection); or b) having direct contact with infectious secretions (e.g., being coughed on) while not wearing recommended personal protective equipment. Currently brief interactions (walking by a person, are considered low risk and do not constitute close contact). ³ Check who website for countries with reported 2019-nCoV cases <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports>