

Internal use

CRDM PUI form no: _____
CRDM unique no: _____

Patient under investigation (PUI) form: Request for 2019-nCoV Testing

Please note that the original case investigation forms should be sent together with the specimen collection form
Furthermore, the completed case investigation form must be scanned and emailed to ncov@nicd.ac.za as detailed below
Tel: (+27)3866392/ (+27) 3866410 | Fax: (+27)11 8829979 | **Hotline: 082 883 9920** | Queries / submission: ncov@nicd.ac.za

Today's date: DD/MM/YYYY Form completed by (Name, Surname): _____ Contact number(s): _____

Is this a: **New clinical query** **If contact of a known case, provide case details:** **Known case first name:** _____
Contact of a known case **Known case surname:** _____
Known case DOB: DD/MM/YYYY

Detected at point of entry? Y N Unkn **If yes, date:** DD/MM/YYYY **Please specify the point of entry:** _____

PATIENT DETAILS	DOCTOR'S DETAILS
Patient hospital number (if available): _____	First name: _____
First name: _____ Surname: _____	Surname: _____
DOB: <u>DD/MM/YYYY</u> Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Facility name: _____
Residency: SA resident <input type="checkbox"/> Non-SA resident <input type="checkbox"/> (specify) _____	Contact number/s: _____
Current residential Address¹: _____	Email address: _____
Patient's contact number(s): _____ <small>Please include alternative number</small>	
Please indicate occupation (tick any if apply): Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Working with animals <input type="checkbox"/> Health laboratory worker <input type="checkbox"/> Healthcare worker <input type="checkbox"/> Facility name: _____ Other <input type="checkbox"/> Specify _____	

NEXT OF KIN CONTACT DETAILS (alternative contact details)

First name: _____ **Surname:** _____

Relationship to the patient: _____ **Contact number(s):** _____

CLINICAL PRESENTATION AND HISTORY

Date of symptom onset: DD/MM/YYYY **Date of current consultation/admission:** DD/MM/YYYY

Symptoms (tick all that apply):

Fever ($\geq 38^{\circ}\text{C}$) <input type="checkbox"/>	Sore throat <input type="checkbox"/>	Myalgia/body pains <input type="checkbox"/>
History of fever <input type="checkbox"/>	Shortness of breath <input type="checkbox"/>	General weakness <input type="checkbox"/>
Cough <input type="checkbox"/>	Nausea/vomiting <input type="checkbox"/>	Irritability/confusion <input type="checkbox"/>
Chills <input type="checkbox"/>	Diarrhoea <input type="checkbox"/>	Other <input type="checkbox"/> (specify if other) _____

DIAGNOSIS

- Did the patient have clinical or radiological evidence of pneumonia Y N
- Were chest X-rays (CXR) done: Y N If yes, CXR Findings: _____
- Did the patient have clinical or radiological evidence of acute respiratory distress syndrome (ARDS)? Y N
- Does the patient have another diagnosis/etiology for their respiratory illness? Y (specify) _____ N Unknown

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):

- Have close physical contact² with a **known** 2019-nCoV case? Y N Unkn
- If the patient has been in a close physical contact with a known 2019-nCoV case, please indicate contact setting:
 Healthcare setting Family setting Work place Public transport setting Other Specify: _____
- Patient is a healthcare worker (HCW) who was exposed to patients with severe acute respiratory infections, unless another aetiology has been identified to explain the clinical presentation of the HCW? Y N Unkn
- Is the patient part of a severe respiratory illness cluster of unknown aetiology that occurred within a 14-day period? Y N Unkn
- Patient has visited a health care facility (as a patient or visitor) in a country where hospital-associated 2019-nCoV infections have been reported? Y N Unkn (If yes, complete travel section)
- Has the patient travelled to/from Wuhan City, (Hubei Province, China)³ or area/s with evidence of sustained 2019-nCoV human-to-human transmission, or a declared outbreak? Y N Unkn (If yes, complete travel section)

TRAVEL HISTORY

If patient traveled outside South Africa in the last 14-days, please complete section below for countries visited

Country and city or cities visited	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

- | | | | |
|--|---|--|--|
| Asthma: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | Cardiac disease: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | Chronic kidney disease: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | Chronic liver disease: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> |
| Chronic neurological/neuromuscular disease: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | COPD/ Chronic pulmonary disease: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | Diabetes: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | Immuno-deficiency (excluding HIV) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> |
| HIV: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | Is the patient virally suppressed? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | Recent viral load: _____ | |
| Obesity: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | Pregnancy: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | Trimester: _____ | Tuberculosis: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> |
| Other: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | (specify): _____ | | |

TREATMENT/MANAGEMENT

- | | | | |
|---|---|--|---|
| Patient hospitalised: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | Admitted to ICU: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | Ventilation: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | On ECMO: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> |
| Antibiotics: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | if Yes, list: _____ | Tamiflu/ other antiviral drugs: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unkn <input type="checkbox"/> | |
| White cell count total: _____ | Differential neutrophils/lymphocytes%: _____ | | |
| Has the patient been isolated at: <input type="checkbox"/> Home <input type="checkbox"/> Healthcare facility <input type="checkbox"/> Not isolated <input type="checkbox"/> Other <input type="checkbox"/> Specify: _____ | | | |
| If patient has been isolated at home or at a healthcare facility, please provide date of isolation: <u>DD/MM/YYYY</u> | | | |

OUTCOME

- | | |
|--|-----------------------------------|
| Currently hospitalised: <input type="checkbox"/> | |
| Discharged <input type="checkbox"/> | Discharge date: <u>DD/MM/YYYY</u> |
| Transferred <input type="checkbox"/> | Name of facility: _____ |
| Died <input type="checkbox"/> | Date of death: <u>DD/MM/YYYY</u> |
| 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: healthcare-associated exposure, including providing direct care for nCoV patients, working with healthcare workers infected with nCoV, visiting patients or staying in the same close environment of a nCoV patient. This could also be defined as a healthcare worker working together in close proximity, sharing the same classroom environment with a nCoV patient, traveling together with nCoV patient in any kind of conveyance or living in the same household as a nCoV patient. ³ Check who website for areas/countries with reported 2019-nCoV cases <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports>. Please refer to <http://www.nicd.ac.za/> for most recent version of this document before use.

Once the PUI form has been completed, please complete the contact line list provided. Completed line list/s must be scanned and emailed to ncov@nicd.ac.za