IDPH Coronavirus Novel 2019 Case Report Form

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
IDPH
PROTECTING HEALTH, IMPROVING LIVES

Demographics

Case Name:		Parent/Guardian Name if applicable):	
Date of Birth:	Current Age:	Race:	Ethnicity: Hispanic/Latino ☐Y ☐N ☐U
Marital Status: ☐ Single☐ Married ☐ Divorced ☐ Widowed ☐ Other_____		Speaks English: **YES** **NO** Other:	
Phone:		Email:	
Deceased: **YES** **NO** If YES, did the patient die from this illness or complications from this illness? **YES** **NO**			Deceased Date:
Address Type:		Name of Residential/Congregate Living Facility:	
Address Line 1:			
City:	State:	County:	Zip:
Comments:			

General Illness

Disease/Onset Date:	Diagnosis Date:	Date Medical Care First Sought	Location First Seen
Clinician Name:		Phone:	
Hospital:		Hospital Admission Date:	
		Hospital Discharge Date:	

Clinical

Patient Symptom Status: ☐Still symptomatic, at home ☐Still symptomatic, hospitalized ☐Symptoms resolved ☐Unknown		As of (Date):
☐ Fever-measured Tmax: _____	Date of Fever Onset: _____	☐ Acute Respiratory Distress Syndrome (ARDS)
	☐ Chills	☐ Diarrhea (3 or more loose stools in 24 hours)
☐ Fever -subjective	☐ Headache	☐ Pneumonia (clinical)
☐ Cough	☐ Muscle Aches	☐ Pneumonia (per X-ray)
☐ Shortness of breath	☐ Abdominal pain	☐ Renal Failure
☐ Sore throat	☐ Vomiting	☐ Dialysis started? Date:_____
☐ Rigors	☐ Loss of Taste/Smell	☐ Other symptoms:
Co-Morbid Conditions: ☐Cardiac disease ☐Chronic kidney disease ☐Chronic liver disease ☐Chronic pulmonary disease ☐Current smoker ☐ Diabetes ☐ Former smoker ☐ Hypertension ☐ Immunocompromised ☐ Pregnancy ☐ Other: _____ ☐ None ☐Unknown		

Treatment/Clinical Management

Isolation Status: ☐ Isolated at Home ☐ Isolated at Hospital ☐ Release from Isolation ☐ Deceased						As of (Date):
Was the patient requested to self-quarantine at home?	**YES NO UNK**		Did the patient complete home quarantine?			**YES NO UNK**
Isolation Precautions Implemented:	Droplet	Contact	Standard Only	None	Private Room	Date Implemented:
What PPE (Personal Protective Equipment) did healthcare personnel use when caring for the patient or obtaining specimens? ☐Eye protection ☐Gloves ☐Gown ☐N95 mask ☐Surgical mask ☐None ☐Unknown						Date Implemented:
Is/Was the patient hospitalized in the Intensive Care Unit?	**YES NO**		Is/Was the patient intubated?			**YES NO**
Is/Was the patient on a ventilator?	**YES NO**		Is/Was the patient on ECMO?			**YES NO**
Treatments:					Did patient respond to treatment?	**YES NO**

Laboratory Testing

Was lab testing done? **YES NO**	**Reason for Testing:** ☐Contact to case ☐Contact to undiagnosed high-risk patient ☐Symptomatic w/unknown etiology ☐Hospitalized patient w/severe respiratory illness ☐Outbreak/congregate living exposure ☐Traveled to an affected area ☐Unknown ☐Surveillance testing ☐Other _____					
Were any non-coronavirus respiratory pathogens detected?	**YES NO UNK**		If yes, specify other respiratory pathogens identified:			
If yes, did the patient respond to the appropriate treatment?	**YES NO UNK**					
Specify treatment:						
Was there a diagnosis other than respiratory infection?	**YES NO UNK**		If yes, specify:			
Did the patient have a low lymphocyte count?	**YES NO UNK**		WBC/Leukocyte Count:		Lymphocytes	%
Did the patient have a low platelet count?	**YES NO UNK**		Platelet Count			

	#1	#2	#3
Specimen number:			
Specimen source:			
Specimen collection date:			
Laboratory Name:			

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Ordering facility/provider name:			
Laboratory Results			
Lab result report date:			
Test type(s): Test method:			
Organism identified:			
Lab test result:			
Lab measured result (in units):			
Reference range:			
Lab Comments:			

Exposure History

Exposure Timeframe	☐ 14 days before onset	☐ 14 days after onset
Date of First Exposure:		**Date of Last Exposure**

List name and address information of the potential source of exposure.

Name: Phone:

Address: City: State:

County: Country:

Epidemiologic Data

Is this case a part of an outbreak? **YES NO UNKNOWN**		Outbreak ID (if known)
Patient Occupation:	Name of Employer: **Address:** **City:** **State:** **Zip:**	
Patient Attends/Resides In	☐ Daycare Center ☐ Preschool ☐ School K-12 ☐ College or University ☐ Prison or Jail ☐ Residential Facility ☐ Unknown ☐ Not Applicable ☐ Other: _____	
	Daycare/School/Facility Name:	
Did the patient have close contact [approx. 6 feet] with an ill patient who was confirmed or suspected to have Coronavirus?		**YES NO UNKNOWN**
If yes, contact type?	☐ Community ☐ Domestic travel ☐ Foreign travel ☐ Healthcare setting ☐ Household ☐ No travel ☐ Other ☐ Sexual	
Describe contact**:**		
In the 14 days prior to illness onset, was the patient in a hospital for any reason? (i.e., visiting, working or for treatment)		**YES NO UNKNOWN**
Name of Hospital:	City: State: Country:	
In the 14 days prior to illness onset, was the patient in a clinic or a doctor's office for any reason?		**YES NO UNKNOWN**
Name of Clinic/Office:	City: State: Country:	
Comments		

Contact Information [includes household and intimate contacts and persons in close contact (6 ft for >10 min)]

Contact Name:		Relation to Case	
Date of Birth:	Current Age:	Race:	Ethnicity: Hispanic/Latino ☐Y ☐N ☐U
☐ Address is same as Case	Address (if different from Case):		
Phone:		Email:	
Was Contact ill with fever and/or respiratory symptoms?		**YES NO UNK**	Date of illness onset:
Contact Occupation		Quarantined? **YES NO UNK**	Isolated? **YES NO UNK**
Contact Comments:			
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Phone:		Email:	
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Contact Occupation		Quarantined? **YES NO UNK**	Isolated? **YES NO UNK**
Contact Comments:			

Reporting Information

Date Reported:			
Name of Reporter		Reporting Organization:	
Phone:		Address:	
Comments			

Additional Contact Information: