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_____		Communicates in 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:		Admission Date:	Discharge Date:

Clinical

Patient Symptom Status: ☐Still symptomatic, at home ☐Still symptomatic, hospitalized ☐Symptoms resolved ☐Unknown symptom status ☐Asymptomatic ☐Deceased		As of (Date):
☐ Fever-measured Tmax: _____	Date of Fever Onset: _____	☐ Chest pain
	☐ Muscle Aches	☐ Other symptoms:
☐ Fever -subjective	☐ Diarrhea (3 or more loose stools in 24 hours)	☐ Abnormal EKG
☐ Cough	☐ Vomiting	☐ Acute Respiratory Distress Syndrome (ARDS)
☐ Sore throat	☐ Abdominal cramps	☐ Pneumonia (clinical)
☐ Shortness of breath	☐ Rigors	☐ Pneumonia (per X-ray)
☐ Wheezing	☐ Loss of Taste/Smell	☐ Renal Failure
☐ Headache	☐ Runny nose (rhinorrhea)	☐ Dialysis started? Date:_____
☐ Chills	☐ Fatigue	☐ Acute Respiratory Distress Syndrome (ARDS)
Co-Morbid Conditions: ☐Cardiac disease ☐Chronic kidney disease ☐Chronic liver disease ☐Chronic pulmonary disease ☐Congenital Heart Disease ☐Current smoker ☐Current Vaper ☐Diabetes ☐Former smoker ☐Hypertension ☐Malignancy ☐Obesity ☐Other congenital malformations ☐ Immunocompromised ☐ Pregnancy Due date_____ ☐Seizures ☐Sickle Cell Disease ☐Substance Abuse/Misuse ☐ None ☐Unknown ☐ Other: _____		

Treatment/Clinical Management

Isolation Status: ☐ Isolated at Home ☐ Isolated at Hospital ☐ Release from Isolation ☐ Deceased ☐Unknown						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			
Potential reinfection- Positive ☐ Within 8 weeks ☐ Past 8 Weeks☐ Within 9 weeks ☐ Past 9 weeks **AND**			**Symptomatic YES NO**			

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

Multisystem Inflammatory Syndrome in Children – see page 4

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	☐ Alcohol/Drug Treatment Center ☐ Assisted/Supportive Living ☐ Correction Facility or Jail ☐ Daycare Center ☐ Developmental Disability Facility ☐ Group Home ☐ Homeless Shelter ☐ Independent/Senior Living Facility ☐ Long Term/Skilled Care Facility ☐ Mental Health Facility ☐Military Facility ☐ Unknown ☐ Not Applicable ☐ Other: _____ ☐ College or University ☐ Preschool ☐ School K-12 ☐ 100% In-Person ☐ 100% Remote ☐ Partial Remote ☐Unknown Attendance Type	
	Daycare/School/College/Facility Name:	
If the patient is affiliated with an Illinois college or university, what is affiliation? ☐ Student ☐ Student employed on campus ☐ Teacher/Instructor ☐ Other Campus Staff (non-student, non-instructor) ☐ Unknown		
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:			
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:			
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:			

Reporting Information

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

Additional Contact Information:

Multisystem Inflammatory Syndrome in Children

LHD Only: Does the case meet the criteria for suspect MIS-C?	**YES NO UNK**

Please answer only for individuals under the age of 21:	
Fever (≥100.4 F or ≥38 C) for at least 24 hours:	**YES NO UNK**
If yes, number of days:	
BMI	_____
Severe abdominal pain	**YES NO UNK**

Did the person have severe multi-system organ involvement (≥2):

Hypotension	**YES NO UNK**	Valvulitis	**YES NO UNK**
Shock (cardiogenic or vasogenic)	**YES NO UNK**	Coronary artery dilation	**YES NO UNK**
Myocarditis	**YES NO UNK**	Renal Disease	**YES NO UNK**
Pericarditis	**YES NO UNK**	Neurologic Disease	**YES NO UNK**
Rash/other severe dermatologic findings	**YES NO UNK**	Other: (describe)	

Laboratory Findings

Elevated d-dimer	**YES NO UNK**
Elevated ferritin	**YES NO UNK**
Elevated troponin	**YES NO UNK**
Elevated pro-BNP	**YES NO UNK**
Elevated C-reactive protein (CRP)	**YES NO UNK**
Elevated erythrocyte sedimentation rate (ESR)	**YES NO UNK**
Elevated fibrinogen	**YES NO UNK**
Elevated procalcitonin	**YES NO UNK**
Elevated lactic acid dehydrogenase (LDH)	**YES NO UNK**
Elevated interleukin 6 (IL-6)	**YES NO UNK**
Elevated neutrophils	**YES NO UNK**
Reduced platelets	**YES NO UNK**
Reduced lymphocytes	**YES NO UNK**
Low albumin	**YES NO UNK**
Was there an alternate or more plausible diagnosis such as bacterial sepsis or other viral infection (including toxic shock)?	**YES NO UNK**
If yes, what was the alternative diagnosis?	