

# DRAFT Novel Coronavirus CASE Form

**CONFIDENTIAL**

v0.5 April 2013  
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Date of Notification to Public Health Department:

**Possible case: please complete page 1&2**  
**Confirmed case: please complete pages 1-4**  
**Outcome details: please complete page 4 ALL CASES**

## PATIENT INFORMATION

Case ID  Surname  Forename

Sex: F ☐ M ☐ Unk ☐ Date of Birth:  Age (years):

Address

HSE Area  CCA  Phone number

Email address  Country of birth

Occupation

GP Name  GP email

GP Address

GP Phone  GP Fax

## CLINICAL DETAILS

Case type: Sporadic ☐ Secondary ☐ Imported ☐

If imported, probable country of infection

Date of onset of 1st symptoms:  Date of diagnosis:

**Symptoms**

Cough ☐ Runny nose ☐ Headache ☐ Shortness of breath ☐

Sneezing ☐ Sore throat ☐ Fever  $\geq 38^{\circ}\text{C}$  ☐ History of fever  $\geq 38^{\circ}\text{C}$  (previous 14 days) ☐

Other symptom, please specify

Chest x-ray evidence of pneumonia Yes ☐ No ☐ Unknown ☐

Suspicion parenchymal disease based on clinical evidence of pneumonia Yes ☐ No ☐ Unknown ☐

Did the case develop ARDS? Yes ☐ No ☐ Unknown ☐ ARDS onset date

Hospitalised due to nCov infection Yes ☐ No ☐ Unknown ☐ Name of hospital

Date of hospital admission  Date of hospital discharge

Was case mechanically ventilated? Yes ☐ No ☐ Unknown ☐

Date mechanical ventilation started  Date mechanical ventilation finished

Duration of mechanically ventilation (days)

Was the case admitted to ICU Yes ☐ No ☐ Unknown ☐

Date of admission to ICU  Date of discharge from ICU

Did the case develop renal failure? Yes ☐ No ☐ Unknown ☐

Did case undergo ECMO? Yes ☐ No ☐ Unknown ☐ Duration of ECMO (days)

ECMO abroad Yes ☐ No ☐ Unknown ☐

ECMO country

Outcome: Recovered ☐ Recovering ☐ Deceased ☐ Unknown ☐

## LABORATORY DETAILS

Were specimens sent for respiratory viral screen? Yes ☐ No ☐ Unknown ☐

Results of respiratory viral screen result (tick all positive result that apply)

Influenza A	Adenovirus	HMPV	PIV2
Influenza B	RSV	PIV1	PIV3

If other respiratory viral screen result, please specify:

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## EXPOSURE DETAILS

Did this possible case have contact with a confirmed case of Novel Coronavirus 10 days prior to onset? Yes ☐ No ☐ Unk ☐

If yes, please give name of contact

Did this possible case travel **outside Ireland** 10 days prior to onset? Yes ☐ No ☐ Unknown ☐

Country (visited by CASE)	Airport of arrival	Departure date	Arrival date	Flight number

Did this possible case travel **within Ireland** 10 days prior to onset? Yes ☐ No ☐ Unknown ☐

Town (visited by CASE)	Departure date	Arrival date

Did this possible case have contact with someone who travelled to the Middle East (ME) 10 days prior to onset? Yes ☐ No ☐ Unk ☐

If yes, what is the case's relationship with traveller returned from ME?

Country (visited by CONTACT)	Departure date	Arrival date	Flight number

Did the case have contact with any of the following during the 10 days prior to onset?

Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/>
Cow <input type="checkbox"/>	Goat <input type="checkbox"/>	Bat <input type="checkbox"/>	Other animal <input type="checkbox"/>
Camel <input type="checkbox"/>	Sheep <input type="checkbox"/>	Civet <input type="checkbox"/>	

If contact with other animal, please specify:

Location where animal contact occurred

## OCCUPATIONAL EXPOSURE DETAILS

Is the case a Health Care Worker (HCW)? Yes ☐ No ☐ Unknown ☐

HCW job title

Direct patient contact? (e.g. hands on clinical contact) Yes ☐ No ☐ Unknown ☐

HCW caring for patients with SARI in ICU? Yes ☐ No ☐ Unknown ☐

Type of patients cared for i.e. ICU, outpatients etc

Does the case work in a laboratory handling specimens suspected to contain nCoV? Yes ☐ No ☐ Unknown ☐

Name & address of Health Care Facility/ laboratory where employed

## CLUSTER DETAILS

Part of cluster? Yes ☐ No ☐ Unknown ☐ Number symptomatic in cluster

CIDR outbreak ID

Details of cluster location/setting

## Comments

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**CLINICAL DETAILS - EXTENDED (Confirmed cases only)**

**Symptoms (continued):**

Arthralgia ☐ Diarrhoea ☐ Anorexia ☐ Nose bleed ☐ Fatigue ☐ Seizures ☐  
Myalgia ☐ Vomiting ☐ Nausea ☐ Headache ☐ Rash ☐ Conjunctivitis ☐  
Altered consciousness ☐  
Other please specify

Maximum temp (°C)

**Complications:**

Cardiac arrest ☐ Chest X-ray evidence of pneumonia ☐ Hypotension requiring vasopressors ☐

**Underlying medical conditions: *please tick all that apply***

Chronic heart disease ☐ Chronic neurological disease ☐ Transplant recipient (organ/marrow) ☐  
Chronic kidney disease ☐ Chronic liver disease ☐ HIV/ Other immunosuppressive illness ☐  
Diabetes ☐ BMI  Malignancy ☐  
Chronic respiratory disease (excl. asthma requiring medication) ☐ Asthma requiring medication ☐

Other co-morbidity, please specify:

Was the case pregnant? Yes ☐ No ☐ Unknown ☐ Pregnancy outcome   
If yes, what is the current trimester? 1st ☐ 2nd ☐ 3rd ☐ Estimated delivery date

Does the case currently smoke? Yes ☐ No ☐ Unknown ☐

Case vaccinated with pneumococcal vaccine? Yes ☐ No ☐ Unk ☐ Pneumococcal vaccine date   
Case vaccinated with current seasonal influenza vaccine? Yes ☐ No ☐ Unk ☐ Influenza vaccine date

Antiviral treatment prescribed? Ribavirin only ☐ Other antiviral ☐ Antiviral combination ☐  
Ribavirin Start date  Other antivirals start date   
Ribavirin finish date  Other antivirals finish date

Visited GP? Yes ☐ No ☐ Unknown ☐  
1st GP visit date  2nd GP visit date  3rd GP visit date

Visited ED? Yes ☐ No ☐ Unknown ☐  
1st ED visit date  2nd ED visit date  3rd ED visit date

**Case admitted to hospital?** Yes ☐ No ☐ Unknown ☐

Name of 1st admitting hospital  Date of 1st admission   
1st discharge diagnosis  Date of 1st discharge   
1st Hospital admission source: Community ☐ Other ward in same hospital ☐ Other hospital ☐

Name of 2nd admitting hospital  Date of 2nd admission   
2nd discharge diagnosis  Date of 2nd discharge   
2nd Hospital admission source: Community ☐ Other ward in same hospital ☐ Other hospital ☐

Name of 3rd admitting hospital  Date of 3rd admission   
3rd discharge diagnosis  Date of 3rd discharge   
3rd Hospital admission source: Community ☐ Other ward in same hospital ☐ Other hospital ☐

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## LABORATORY RESULTS (Confirmed cases only)

Laboratory name	<input type="text"/>			Specimen ID	<input type="text"/>											
Specimen collected date	<input type="text"/>			NCoV test result	Pos	<input type="checkbox"/>	Neg	<input type="checkbox"/>	equivocal	<input type="checkbox"/>						
Laboratory result date	<input type="text"/>															
Specimen type	BAL	<input type="checkbox"/>	Plasma	<input type="checkbox"/>	Nose swab	<input type="checkbox"/>	Sputum	<input type="checkbox"/>	Finger prick	<input type="checkbox"/>	Faeces	<input type="checkbox"/>				
	NPA	<input type="checkbox"/>	Serum	<input type="checkbox"/>	Throat swab	<input type="checkbox"/>	Oral fluid	<input type="checkbox"/>	Tissue	<input type="checkbox"/>						
Was baseline serology taken on case?				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown	<input type="checkbox"/>							
Date baseline serology taken				<input type="text"/>				Date baseline serology sent to NVRL				<input type="text"/>				

## OUTCOME DETAILS - All

Case classification: Confirmed ☐ Possible ☐ Denotified ☐ Lost to follow up ☐ Unknown ☐

Outcome Still ill ☐ Recovering ☐ Recovered ☐ Deceased ☐ Unknown ☐

Date of symptom resolution in the case  If deceased, date of death:

If deceased, was nCoV contributing factor: Underlying/primary ☐ No contribution to death ☐ Unknown ☐
  
 Contributory/secondary ☐ Awaiting Coroners report ☐ Pending ☐

Was a post-mortem examination performed? Yes ☐ No ☐ Unknown ☐

Cause of death as per medical certificate of death

Result of coroners report (where applicable)

## SECONDARY BACTERIAL INFECTIONS

Did case have secondary bacterial infection Yes ☐ No ☐ Unknown ☐

If yes, please specify positive result: H. influenzae ☐ S. aureus ☐ E. coli ☐
  
 S. pneumoniae ☐ MRSA ☐ Other organism ☐

Other organism, please specify:

## POST-EXPOSURE SEROLOGY (21 days after 1<sup>st</sup> exposure)

Was post-exposure serology (21 days after exposure) taken on case? Yes ☐ No ☐ Unknown ☐

Date post-exposure serology taken  Date post-exposure serology sent to NVRL

## REPORTER DETAILS

Reporter name	<input type="text"/>	Reporter position	<input type="text"/>
Reporter phone	<input type="text"/>	Reporter email	<input type="text"/>
Reporter HSE	<input type="text"/>	Reporter fax	<input type="text"/>
Date of case interview	<input type="text"/>	Date case notified to HPSC	<input type="text"/>