

**PATIENT INFORMATION**

Date of Notification to Public Health Department:

CIDR outbreak ID

Contact ID  Case ID

Contact Surname  Contact Forename

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

Address

Home phone number  Work phone number

HSE Area  CCA  Mobile number

Email address  Country of birth

Occupation

GP Name  GP email

GP Address

GP Phone  GP Fax

**PRELIMINARY CONTACT DETAILS**

Type of contact with confirmed case: Healthcare worker (HCW) ☐ Relative/ friend ☐ Other ☐

If other type of contact with confirmed case, please specify

Location of contact with confirmed case: Household ☐ Health Care Facility (HCF) ☐ School ☐ Other ☐

If other location, please specify:

Date last unprotected contact with confirmed case

**CLINICAL DETAILS**

**If contact becomes symptomatic, please complete the CASE form**

Was contact ill in the 10 days PRIOR to onset of illness in confirmed case? Yes ☐ No ☐ Unknown ☐

Was contact ill in the 10 days POST onset of illness in confirmed case? Yes ☐ No ☐ Unknown ☐

Date of onset of 1st symptoms:  Time of onset of 1st symptoms (24hr):

**Underlying medical conditions: (of the CONTACT)**

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) ☐ Seizure disorder ☐

Asthma requiring medication ☐

Other co-morbidity, please specify:

Was the contact pregnant? Yes ☐ No ☐ Unknown ☐ Estimated delivery date

If yes, what is the current trimester? 1st ☐ 2nd ☐ 3rd ☐

Yes ☐ No ☐ Unk ☐

Contact vaccinated with pneumococcal vaccine? ☐ ☐ ☐ Pneumococcal vaccine date

Contact vaccinated with current seasonal influenza vaccine? ☐ ☐ ☐ Influenza vaccine date

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

### HEALTH CARE EXPOSURE DETAILS

Work address

Is the contact a Health Care Worker (HCW)? Yes ☐ No ☐ Unknown ☐ HCW job title

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

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

Date first HCW unprotected contact with confirmed case w/out full PPE

Date last HCW unprotected contact with confirmed case w/out full PPE

#### Details of PPE used with confirmed case:

	Yes	No	Unk		Always (100% of time)	Often (>50% of time)	Infrequent (<50% of time)	Never
SurgicalMask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, frequency of surgical mask use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FFP2/ FFP3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, frequency of FFP2/FFP3 use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye protection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, frequency of eye protection use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gloves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, frequency of glove use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, frequency of gown use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Did HCW contact occur during any aerosol generating procedures? Yes ☐ No ☐ Unknown ☐

#### Aerosol generating procedure type

#### Mask used during aerosol generating procedure?

#### Aerosol generating procedure date

<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	<input type="text"/>
<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	<input type="text"/>

If date of onset in the confirmed case is known, please give dates of contact with case post-onset of symptoms in the case

Day	Date of onset of illness (confirmed case)	1 day post onset	2 days post onset	3 days post onset	4 days post onset	5 days post onset
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Day	6 days post onset	7 days post onset	8 days post onset	9 days post onset	10 days post onset	11 days post onset
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Day	12 days post onset	13 days post onset	14 days post onset	If onset in the confirmed case is UNKNOWN, please give the total days of contact with case post-onset of their symptoms <input type="text"/>		
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>			

### NON-HEALTH CARE EXPOSURE DETAILS

Date of first non-HCW contact with confirmed case

Date of last non-HCW contact with confirmed case

If date of onset in the confirmed case is known, please give dates of contact pre & post-onset of symptoms in the case

Day	10 days PRE-onset of illness (confirmed case)	9 days PRE-onset	8 days PRE-onset	7 days PRE-onset	6 days PRE-onset	5 days PRE-onset
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Day	4 days PRE-onset	3 days PRE-onset	2 days PRE-onset	1 day PRE-onset	Date of onset of illness (confirmed case)	1 day POST-onset
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Day	2 days POST-onset	3 days POST-onset	4 days POST-onset	5 days POST-onset	6 days POST-onset	7 days POST-onset
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Day	8 days POST-onset	9 days POST-onset	10 days POST-onset			
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>			

If onset in the confirmed case is UNKNOWN, please give the total days of contact with case post-onset of their symptoms

**LABORATORY DETAILS**

*(If the contact becomes symptomatic and requires tests)*

1st laboratory name	<input type="text"/>	1st specimen ID	<input type="text"/>
1st specimen collected date	<input type="text"/>	1st test type	Molecular <input type="checkbox"/> Culture <input type="checkbox"/> Serological <input type="checkbox"/>
1st laboratory test date	<input type="text"/>	1st result	Pos <input type="checkbox"/> Neg <input type="checkbox"/> equivocal <input type="checkbox"/>
1st specimen type	1st virus detected <input type="text"/>		
BAL <input type="checkbox"/>	Plasma <input type="checkbox"/>	Nose swab <input type="checkbox"/>	Sputum <input type="checkbox"/>
NPA <input type="checkbox"/>	Serum <input type="checkbox"/>	Throat swab <input type="checkbox"/>	Oral fluid <input type="checkbox"/>
		Finger prick <input type="checkbox"/>	Faeces <input type="checkbox"/>
		Tissue <input type="checkbox"/>	

2nd laboratory name	<input type="text"/>	2nd specimen ID	<input type="text"/>
2nd specimen collected date	<input type="text"/>	2nd test type	Molecular <input type="checkbox"/> Culture <input type="checkbox"/> Serological <input type="checkbox"/>
2nd laboratory test date	<input type="text"/>	2nd result	Pos <input type="checkbox"/> Neg <input type="checkbox"/> equivocal <input type="checkbox"/>
2nd specimen type	2nd virus detected <input type="text"/>		
BAL <input type="checkbox"/>	Plasma <input type="checkbox"/>	Nose swab <input type="checkbox"/>	Sputum <input type="checkbox"/>
NPA <input type="checkbox"/>	Serum <input type="checkbox"/>	Throat swab <input type="checkbox"/>	Oral fluid <input type="checkbox"/>
		Finger prick <input type="checkbox"/>	Faeces <input type="checkbox"/>
		Tissue <input type="checkbox"/>	

3rd laboratory name	<input type="text"/>	3rd specimen ID	<input type="text"/>
3rd specimen collected date	<input type="text"/>	3rd test type	Molecular <input type="checkbox"/> Culture <input type="checkbox"/> Serological <input type="checkbox"/>
3rd laboratory test date	<input type="text"/>	3rd result	Pos <input type="checkbox"/> Neg <input type="checkbox"/> equivocal <input type="checkbox"/>
3rd specimen type	3rd virus detected <input type="text"/>		
BAL <input type="checkbox"/>	Plasma <input type="checkbox"/>	Nose swab <input type="checkbox"/>	Sputum <input type="checkbox"/>
NPA <input type="checkbox"/>	Serum <input type="checkbox"/>	Throat swab <input type="checkbox"/>	Oral fluid <input type="checkbox"/>
		Finger prick <input type="checkbox"/>	Faeces <input type="checkbox"/>
		Tissue <input type="checkbox"/>	

**SEROLOGY: Applies to all contacts**

Was baseline serology taken on the contact?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Date baseline serology taken	<input type="text"/>
Name of laboratory baseline serology sent to	<input type="text"/>
Was post-exposure serology (21 days after 1st exposure) taken on the contact?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Date post-exposure serology taken	<input type="text"/>
Name of laboratory post-exposure serology sent to	<input type="text"/>
Date convalescent serology sent to NVRL	<input type="text"/>

**OUTCOME DETAILS**

	Yes	No	Unk
Did the contact become symptomatic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the contact investigated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was novel coronavirus diagnosed in this contact?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outcome	Still ill <input type="checkbox"/>	Recovering <input type="checkbox"/>	Recovered <input type="checkbox"/>
	Deceased <input type="checkbox"/>	Unknown <input type="checkbox"/>	
If deceased, date of death:	<input type="text"/>		

**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"/>