COVID-19 CASE FORM
CONFIDENTIAL

hpsc

CIDR Event ID _____ HSE Area _____

PATIENT DETAILS

Surname
Forename
Sex M ☐ F ☐ Unk ☐
Date of Birth
Country of Birth
Ethnicity[1]
Address
County
EirCode
Phone No.

Occupational Category[2]
Occupational Role
Name of Workplace
Address of Workplace

Does Case live in a Residential Facility? Yes ☐ No ☐ Unknown ☐

If yes, Type of Residential Facility[3]
Residential Facility ID (from HSE Services Directory list)
Name of Residential Facility

CLINICAL DETAILS

Is patient symptomatic? Yes ☐ No ☐ Unknown ☐

Date of onset of symptoms:

If yes, please mark patient symptoms:

	Yes	No	Unknown
Cough	☐	☐	☐
Shortness of Breath	☐	☐	☐
Fever	☐	☐	☐
Sore throat	☐	☐	☐
Runny/stuffy nose	☐	☐	☐
Loss of Taste	☐	☐	☐
Loss of Smell	☐	☐	☐
Diarrhoea	☐	☐	☐
Nausea/Vomiting	☐	☐	☐
Aches and pains	☐	☐	☐
Tiredness	☐	☐	☐
Headaches	☐	☐	☐
Other	☐	☐	☐

If other please specify:

Date of laboratory diagnosis:

Date case placed in isolation:

Was patient hospitalised? Yes ☐ No ☐ Unknown ☐

Date of hospital admission:

If Hospital Inpatient:

Hospital name

Admitted to ICU? Yes ☐ No ☐ Unknown ☐

Date of admission to ICU:

UNDERLYING CLINICAL CONDITIONS? Yes ☐ No ☐ Unknown ☐

Please tick all that apply

	Yes
Chronic heart disease	☐
Hypertension	☐
Chronic neurological disease	☐
Chronic respiratory disease	☐
Chronic kidney disease	☐
Chronic liver disease	☐
Asthma requiring medication	☐
Immunodeficiency, including HIV	☐
Diabetes	☐
BMI ≥40	☐
Cancer/ Malignancy	☐

Is this case pregnant: Yes ☐ No ☐ Unknown ☐

Smoker: Yes ☐ No ☐ Unknown ☐

Did patient have Paediatric Inflammatory Multi-System Syndrome (PIMS): Yes ☐ No ☐ Unknown ☐

Other co-morbidities, please specify:

NOTES

[1,2,3] For list of Ethnicities, Occupations, and Residental Facilities please reference the appendix on Page 5.

OCCUPATIONAL HEALTHCARE EXPOSURE STATUS

Is the case <u>currently employed</u> as a Healthcare Worker (HCW)? Yes ☐ No ☐ Unknown ☐

If **yes**, please specify HCW ROLE

- ☐ Nurse
- ☐ Doctor
- ☐ Physiotherapist
- ☐ Occupational therapist
- ☐ Speech and Language Pathologist
- ☐ Dietician
- ☐ Pharmacy Worker
- ☐ Radiographer
- ☐ Healthcare Assistant
- ☐ Medical Student/ Student Doctor
- ☐ Student Nurse
- ☐ Porter
- ☐ Cleaning/household staff
- ☐ Catering/Kitchen worker in healthcare facility
- ☐ Home Care
- ☐ Admin/Clerical worker in healthcare facility
- ☐ Other

If other please specify: _____

If **yes**, please specify TYPE OF HEALTHCARE FACILITY

- ☐ Acute Hospital
- ☐ Hospice
- ☐ GP Surgery
- ☐ Nursing Home
- ☐ Testing site or Assessment hub for COVID-19
- ☐ Prison
- ☐ Homeless Facility - hub/hostel/hotel
- ☐ Direct Provision Centre
- ☐ Mental Health Facility
- ☐ Other
- ☐ Community Hospital/Long Term Stay Unit
- ☐ Women/Children's Refuge Facility
- ☐ Designated Centre for Adults and Children with Disabilities
- ☐ Community Services

If other HCW place of work please specify: _____

Name of Healthcare Facility where employed: _____

Address of Healthcare Facility where employed: _____

OCCUPATIONAL HEALTHCARE EXPOSURE STATUS

Is appropriate PPE Available in the healthcare facility where you work? Yes ☐ No ☐ Unknown ☐

Are you a HCW who has direct contact with patients/residents with confirmed/suspected COVID-19? Yes ☐ No ☐ Unknown ☐

If yes, appropriate use of the following PPE as per your workplace guidance:

	Always (100% of time)	Often (>50% of time)	Infrequent (<50% of time)	Never
Surgical mask	☐	☐	☐	☐
FFP2 / FFP3	☐	☐	☐	☐
Eye protection	☐	☐	☐	☐
Gloves	☐	☐	☐	☐
Gown	☐	☐	☐	☐

If PPE not always used (i.e. 100%): Date first contact with case: ____/____/____ Date last contact with case: ____/____/____

When in contact with patients/residents with confirmed/suspected COVID-19, did you perform an Aerosol Generating Procedure? **Yes** ☐ **No** ☐ **Unknown** ☐

If yes, details of aerosol generating procedures

Procedure type	Was FFP2/FFP3 mask used during procedure		
1.	Yes ☐	No ☐	Unknown ☐
2.	Yes ☐	No ☐	Unknown ☐
3.	Yes ☐	No ☐	Unknown ☐

TRAVEL-RELATED EXPOSURE DETAILS

International travel in the previous 14 days? Yes ☐ No ☐ Unknown ☐

If yes, port/airport of arrival in Ireland: _____ Arrival date in Ireland: _____

If yes, provide International Travel Accommodation details:

	Country	City/Town	Accommodation Name/Address	Arrival date	Departure date	Duration of stay (days)
1.						
2.						
3.						

International Travel Accommodation Type (Select from List*):	If other International Accommodation please specify:
1.	
2.	
3.	

If yes, provide International Travel details:

	Airline/Ferry	Flight/Ferry No.	Departure date	Arrival date
1.				
2.				
3.				

If yes International Travel, Country and Location of Exposure:

If yes, please specify additional details including airport layovers:

Domestic travel within Ireland in the 14 days prior to symptom onset? Yes ☐ No ☐ Unknown ☐

	Departure Location	Arrival Location	Date of travel	Overnight Stay?	Duration of stay (days)
1.				Y N U	
2.				Y N U	
3.				Y N U	

Domestic Travel 1 Details:

Mode of Transport 1 (Select from List**): _____ If Other Domestic Mode of Transport 1 please specify: _____

Domestic Travel Accommodation 1 Type (Select from List*): _____ If Other Domestic Accommodation 1 please specify: _____

Accommodation 1 Name/Address: _____ Accommodation 1 County: _____

Domestic Travel 2 Details:

Mode of Transport 2 (Select from List**): _____ If Other Domestic Mode of Transport 2 please specify: _____

Domestic Travel Accommodation 2 Type (Select from List*): _____ If Other Domestic Accommodation 2 please specify: _____

Accommodation 2 Name/Address: _____ Accommodation 2 County: _____

Domestic Travel 3 Details:

Mode of Transport 3 (Select from List**): _____ If Other Domestic Mode of Transport 3 please specify: _____

Domestic Travel Accommodation 3 Type (Select from List*): _____ If Other Domestic Accommodation 3 please specify: _____

Accommodation 3 Name/Address: _____ Accommodation 3 County: _____

***Types of Accommodation:**
Hotel
Hostel
Guest House/BnB
Holiday Home
Caravan/Camping Park
Relative or Friend's Home
Other

****Modes of Transport:**
Train
Bus
Ferry
Taxi
Private Car
Domestic Flight
Motor Bike
Other

EXPOSURE DETAILS (CONT.)

Did case attend a mass gathering event (e.g. concert, match, cinema, etc.)? **Yes** ☐ **No** ☐ **Unknown** ☐

☐ Wedding ☐ Cinema ☐ Sporting Event ☐ Other

☐ Funeral ☐ Concert ☐ Religious Service

If other, please specify: _____

Name and Location of Event: _____

Date of Event: _____

Was case diagnosed as part of mass testing programme? **Yes** ☐ **No** ☐ **Unknown** ☐

☐ Nursing home HCW mass testing ☐ NCHD mass testing

☐ Defence Forces (i.e. army) ☐ Other If other, please specify: _____

PATIENT OUTCOME

Outcome ☐ Still ill ☐ **Recovered** ☐ **Died** ☐ Unknown

If recovered, date of recovery: _____ **If died,** date of death: _____

If **Died**, please specify place of death:

☐ Ambulance/Transit to Hospital ☐ Hospice ☐ Direct Provision Centre

☐ Hospital – Emergency Department ☐ Prison ☐ Community Hospital/Long Term Stay Unit

☐ Hospital – Ward Non-ICU ☐ Homeless Facility - hub/hostel/hotel ☐ Mental Health Facility

☐ Hospital – Ward HDU ☐ Nursing Home ☐ At Home

☐ Hospital – Ward ICU ☐ Outdoors – Street/Park ☐ Other

If other Place of Death please specify: _____

EPIDEMIOLOGICAL DETAILS

Case classification[4] ☐ Confirmed ☐ Probable ☐ Possible

Most Likely Transmission Source

☐ Close contact with a confirmed case in the 14 days prior to onset[5] ☐ Travel Related* ☐ Community Transmission**

☐ Nosocomial Transmission in HCW / other worker in HC setting ☐ Nosocomial Transmission in patient (with known contact of case) in HC setting

*including cases with international travel in the last 14 days/imported cases/cases that are contacts of travel related cases or cases linked to travel related clusters. This includes local transmission that relates to travel.

** with no known transmission source identified following investigation.

INTERVIEWER DETAILS

Interviewer name	
Interviewer phone	
Interviewer position	
Interviewer email	

Date of case interview _____

NOTES

4. Please refer to the latest **case definition** available at https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casedefinitions/

5. For latest definition of close contact please refer to the latest version of the COVID-19 Contact Tracing Guidelines available at https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/contacttracingguidance

Appendix

1. For ethnicity, please enter one of the following options:

Black African	Irish Traveller	Not known
Black Other	Roma	Not specified
Chinese	White	Other (if other please specify)
Indian Subcontinent	Mixed Background	

2. For occupation, please enter one of the following options:

- Army Occupations
- Building and construction workers
- Business and commerce occupations
- Central and Local Government workers
- Chemical, paper, wood, rubber, plastics and printing workers
- Clerical and office workers
- Communication, warehouse and transport workers
- Computer software occupations
- Electrical trades workers
- Engineering and allied trades
- Farming, fishing and forestry workers
- Food, drink and tobacco production workers
- Garda Siochana
- Health and related workers
- Managers and executives
- Not Specified
- Not Stated
- Other gainful occupations
- Other manufacturing workers
- Other professional workers
- Personal service and childcare workers
- Religious occupations
- Sales occupations
- Scientific and technical occupations
- Social workers and related occupations
- Students incl. schoolchildren
- Teachers

3. For type of residential facility, please enter one of the following options:

Homeless Facility – Hub/Hostel/Hotel	Prison
Direct Provision Centre	Women/Children's Refuge Facility
Nursing Home	Designated Centre for Adults/Children with Disabilities
Community Hospital/Long Stay Unit	Residential Institution
Mental Health Facility	Other (if other, please specify)

ADDITIONAL DETAILS / NOTES

Please use this page to capture details which you could not fit on pages 1-4.