North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

North Carolina Public Health

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

COVID-19 (CORONAVIRUS INFECTION)
Confidential Communicable Disease Report—Part 2

ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease. Enter all information from this form into the NC EDSS question packages.

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

CLINICAL FINDINGS

Is/was patient symptomatic for this disease? ☐ Y ☐ N ☐ U

If yes, symptom onset date (mm/dd/yyyy): __/__/____

Fever ☐ Y ☐ N ☐ U
☐ Yes, subjective ☐ No
☐ Yes, measured ☐ Unknown
Highest measured temperature_____
Fever onset date (mm/dd/yyyy):____/____/____

Sweats (diaphoresis) ☐ Y ☐ N ☐ U

Chills or rigors ☐ Y ☐ N ☐ U

Headache ☐ Y ☐ N ☐ U

Muscle Aches ☐ Y ☐ N ☐ U

Sore Throat ☐ Y ☐ N ☐ U

Cough ☐ Y ☐ N ☐ U
Onset date (mm/dd/yyyy):____/____/____
Productive ☐ Y ☐ N ☐ U
If yes, Describe (check all that apply)
☐ Clear ☐ Bloody (hemoptysis)
☐ Purulent

Shortness of breath/difficulty breathing/ respiratory distress

Acute Respiratory Distress Syndrome (ARDS) ☐ Y ☐ N ☐ U

Pathology consistent with respiratory distress syndrome ☐ Y ☐ N ☐ U

Did the patient have a chest x-ray? ☐ Y ☐ N ☐ U
If yes, Describe (check all that apply)
☐ Normal
☐ Infiltrate
☐ Diffuse infiltrates / findings suggestive of ARDS
☐ Pleural effusion
☐ Other

Pneumonia ☐ Y ☐ N ☐ U
Confirmed by x-ray or CT ☐ Y ☐ N ☐ U

Abdominal pain/cramps ☐ Y ☐ N ☐ U

Vomiting ☐ Y ☐ N ☐ U

Diarrhea ☐ Y ☐ N ☐ U
Describe (select all that apply)
☐ Bloody ☐ Non-bloody ☐ Watery ☐ Other

Other symptoms, signs, clinical findings, or complications consistent with this illness
If yes, Please specify: ☐ Y ☐ N ☐ U

REASON FOR TESTING

Why was the patient tested for this condition?

☐ Symptomatic of disease
☐ Screening of asymptomatic person with reported risk factor(s)
☐ Exposed to organism causing this disease (asymptomatic)
☐ Household / close contact to a person reported with this disease
☐ Other, specify_____
☐ Unknown

PREDISPOSING CONDITIONS

Other dx/etiology for respiratory illness ☐ Y ☐ N ☐ U

Any immunosuppressive conditions? ☐ Y ☐ N ☐ U

☐ Diabetes
☐ Metabolic Disorder
☐ Hematologic Disorder
☐ Cardiovascular/heart disease
☐ Kidney Disease
☐ Chronic Lung Disease
☐ Neuromuscular Disorder
☐ Moderate/severe dev disorder
☐ Seizure Disorder

Specify _____

TREATMENT

Did the patient receive an antiviral for this illness? ☐ Y ☐ N ☐ U
Specify antiviral name: _____
Date antiviral treatment began (mm/dd/yyyy):____/____/____
Time treatment began:_____ ☐ AM ☐ PM
Number of days taken:_____ ☐ Unknown

Did the patient require supplemental oxygen? ☐ Y ☐ N ☐ U
Date started (mm/dd/yyyy):____/____/____

Did the patient require intubation? ☐ Y ☐ N ☐ U

Did the patient require mechanical ventilation? ☐ Y ☐ N ☐ U
Date started (mm/dd/yyyy):____/____/____
Number of days on mechanical ventilation:_____

Was the patient on ECMO? ☐ Y ☐ N ☐ U

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐ Y ☐ N ☐ U
Hospital name: _____
City, State:_____
Hospital contact name: _____
Telephone: (_____) _____ - _____
Admit date (mm/dd/yyyy): ____/____/____ Discharge date (mm/dd/yyyy):____/____/____
Number of Days Hospitalized _____
ICU admission? ☐ Y ☐ N ☐ U
Medical Record # _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? ☐ Y ☐ N

Check all that apply:

☐ Work ☐ Sexual behavior
☐ Child care ☐ Blood and body fluid
☐ School ☐ Other, specify:

_____

Date control measures issued: ____/____/____

Date control measures ended: ____/____/____

Was patient compliant with control measures? ☐ Y ☐ N

Local health director or designee implement additional control measures? ☐ Y ☐ N

If yes, specify: _____

_____ ..

Were written isolation orders issued? ☐ Y ☐ N

If yes, where was the patient isolated?

_____

Date isolation started: ____/____/____

Date isolation ended: ____/____/____

Was the patient compliant with isolation? ☐ Y ☐ N

Were written quarantine orders issued? ☐ Y ☐ N

If yes, where was the patient quarantined?

_____

Date quarantine started: ____/____/____

Date quarantine ended: ____/____/____

Was the patient compliant with with quarantine? ☐ Y ☐ N

Comments about isolation and quarantine:

TRAVEL & IMMIGRATION

The patient is:

☐ Resident of NC
☐ Resident of another state or US territory
☐ Foreign Visitor
☐ Refugee
☐ Recent Immigrant
☐ Foreign Adoptee
☐ None of the above

Did patient have a travel history during the 14 days prior to onset? ☐ Y ☐ N ☐ U

List travel dates and destinations:

From _____/_____/_____ to _____/_____/_____

_____

_____

Mode(s) of transportation (check all that apply)

☐ Airplane ☐ Train / subway
☐ Ship / boat / ferry ☐ On foot
☐ Automobile / motorcycle ☐ Bus/taxi/shuttle
☐ Other, specify: _____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐ Y ☐ N ☐ U

Name: _____

Did patient have contact with a person with travel history during the period of interest? ☐ Y ☐ N ☐ U

Contact's name: _____

Travel dates:

From: ____/____/____ until ____/____/____

To city: _____

To state: _____

To country: _____

BEHAVIORAL RISK & CONGREGATE LIVING

During the 14 days prior to onset of symptoms did the patient live in any congregate living facilities? ☐ Y ☐ N ☐ U

☐ Correctional facility
☐ Barracks
☐ Shelter
☐ Commune
☐ Boarding School
☐ Camp
☐ Dormitory/sorority/fraternity
☐ Assisted Living Facility
☐ No
☐ Other _____

Name of facility: _____

Start date: _____/_____/_____

End date: _____/_____/_____

During the 10 days prior to onset, did the patient attend social gatherings or crowded settings? ☐ Y ☐ N ☐ U

If yes, specify: _____

In what setting was the patient most likely exposed?

☐ Restaurant
☐ Home
☐ Work
☐ Child Care
☐ School
☐ University/College
☐ Camp
☐ Doctor's office/Outpatient clinic
☐ Hospital In-patient
☐ Hospital Emergency Dept
☐ Laboratory
☐ Long-term care facility/Rest Home
☐ Military
☐ Prison/Jail/Detention
☐ Place of Worship
☐ Outdoors, incl woods or wilderness
☐ Athletics
☐ Farm
☐ Pool/spa
☐ Pond/lake/river/other body of water
☐ Hotel/motel
☐ Social gathering, other than above
☐ Travel conveyance (air,ship,etc.)
☐ International
☐ Community
☐ Other (specify)

_____

☐ Unknown

Does the patient have any other risk for this disease? ☐ Y ☐ N ☐ U

Specify:

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

_____

Clinical Outcome..... ☐ Survived ☐ Died

Died from this illness? ☐ Y ☐ N ☐ U

Date of death (mm/dd/yyyy): _____/_____/_____

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? ☐ Y ☐ N ☐ U

Patient a child care worker or volunteer in child care? ☐ Y ☐ N ☐ U

Patient a parent or primary caregiver of a child in child care? ☐ Y ☐ N ☐ U

Is patient a student?..... ☐ Y ☐ N ☐ U

Type of school:

☐ NC Public School (preK-12)
☐ NC Private School (preK-12)
☐ Other School (preK-12)
☐ Community College / College / University
☐ Other academic institution (trade, professional, etc)

Name of school: _____

Is patient a school WORKER / VOLUNTEER in NC school setting? ☐ Y ☐ N ☐ U

Type of school:

☐ NC Public School (preK-12)
☐ NC Private School (preK-12)
☐ Other School (preK-12)
☐ Community College / College / University
☐ Other academic institution (trade, professional, etc)

Name of school: _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 14 days prior to onset of symptoms, did the patient have any of the following exposures:

☐ **Emergency Department (not hospitalized)** ..... ☐ Y ☐ N ☐ U

Facility name _____

City _____

State _____

Country _____

☐ **Hospitalized**

Visit / admit date (mm/dd/yyyy):____/____/____

Facility name_____

Has patient been discharged?..... ☐ Y ☐ N ☐ U

Discharge date (mm/dd/yyyy):_____

☐ **Long term care facility - resident (e.g. nursing home, rest home, rehab)**

Visit/admit date (mm/dd/yyyy):_____

Facility name_____

City_____State _____

Country _____

Has patient been discharged? ..... ☐ Y ☐ N ☐ U

Discharge date (mm/dd/yyyy):____/____/____

☐ **Outpatient facility - patient (e.g. urgent care, clinic, physician office)**

Visit / admit date (mm/dd/yyyy):____/____/____

Facility name_____

☐ **Visitor to health care setting**

Visit date (mm/dd/yyyy):____/____/____

Facility name_____

City_____State _____

Country _____

☐ **Worked or volunteered in health care or clinical setting**

Facility name_____

City_____State _____

Country _____

Occupation _____

☐ **Community Contact to a known case**

☐ **Household Contact to a known case**

☐ **No Known Exposure**

☐ **Under Investigation**

☐ **Other, please specify:**

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ..... ☐ Y ☐ N ☐ U

If yes, specify:

During the 14 days prior to symptom onset, did the pt have contact with anyone diagnosed with COVID-19?..... ☐ Y ☐ N ☐ U

Was the contact lab confirmed?

If yes, specify:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed?..... ☐ Y ☐ N ☐ U

Interviewer's name _____

Date of interview (mm/dd/yyyy):_____/_____/_____

Were interviews conducted with others?..... ☐ Y ☐ N ☐ U

Who was interviewed?

- ☐ Employer/supervisor/co-worker
- ☐ Friend/neighbor
- ☐ Guardian
- ☐ Household contact / roommate
- ☐ Parent
- ☐ Other

Were health care providers consulted?..... ☐ Y ☐ N ☐ U

Who was consulted?

- ☐ Infectious Disease Phys
- ☐ PA/FNP
- ☐ Physician
- ☐ Other

Name: _____

Phone: _____

Medical records reviewed (incl telephone review with provider/ office staff)? ..... ☐ Y ☐ N ☐ U

Specify reason medical records not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC

City _____

County_____

☐ Outside NC, but within US

City _____

State _____

County_____

☐ Outside US

City _____

Country _____

☐ Unknown

Is the patient part of an outbreak of this disease? ..... ☐ Y ☐ N

Notes: