**VDH Form for Interviewing Suspected and Confirmed Coronavirus Disease (COVID-2019) Cases**

**Interviewer instructions: Before interviewing the case-patient, please complete the following information:**

Date interview completed: / / (MM/DD/YYYY) Interviewer telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interviewer Name: Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organization/affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Case-Patient Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Case-Patient First and Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 Case ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Hello, my name is \_\_\_\_\_\_ and I’m calling from the \_\_\_\_\_\_ Health Department.*

**If case-patient is unavailable**

For voice mail that does or does not appear to be secure/confidential:

*“The Virginia Department of Health is trying to reach you about an urgent public health issue. Please contact us immediately at INSERT PHONE NUMBER. If no one is available when you call back, please leave a message with your full name and the best phone number where you can be reached.* [If appropriate, you can add: *‘You can also email us at INSERT EMAIL ADDRESS’. Thank you.”*

**If case-patient is available, proceed with the interview.**

*I am calling today because we are closely monitoring the outbreak of respiratory illness caused by the new coronavirus (called COVID-19). We have identified you as potentially being sick with COVID-19.*

*Can you first please confirm the following information?* [Confirm name matches]

*Thank you. Can you please assist in providing some additional information about your illness and exposure as well as those that you may have been in close contact with while you were sick?*

1. Who is providing information for this form?

[ ]  Case-Patient [ ] Parent/guardian [ ]  Healthcare Provider, Name: \_\_\_\_\_\_\_\_\_, Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Other, specify name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Case-Patient’s primary language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was this form administered via a translator? □ Yes □ No

##

## Step 1: Demographics

|  |  |
| --- | --- |
| Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

1. Date of birth: / / (MM/DD/YYYY)
2. Age: \_\_\_\_\_\_\_ [ ]  years [ ]  month [ ]  days
3. Ethnicity: [ ]  Hispanic/Latino [ ]  Non-Hispanic/Latino [ ]  Not Specified
4. Race: [ ] White [ ] Asian [ ] American Indian/Alaska Native [ ] Black

[ ] Native Hawaiian/Other Pacific Islander [ ]  Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Unknown

1. Sex: [ ]  Male [ ] Female [ ]  Unknown [ ]  Other

## Step 2: PUI Form

### Medical History

|  |  |
| --- | --- |
| Was the case-patient hospitalized? [ ]  Yes [ ]  No [ ]  Unknown If yes, facility name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Admit date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Was the patient admitted to an intensive care unit? [ ]  Yes [ ]  No [ ]  UnknownDid the patient receive mechanical ventilation/intubation? [ ]  Yes [ ]  No [ ]  Unknown If yes, total days with MV: \_\_\_\_\_\_\_\_\_\_\_Did the patient receive ECMO? [ ]  Yes [ ]  No [ ]  Unknown | Date of first positive specimen collection: / / (MM/DD/YYYY)  [ ]  N/A [ ]  UnknownDid the patient develop pneumonia?[ ]  Yes [ ]  No [ ]  UnknownDid the patient have acute respiratory distress syndrome?[ ]  Yes [ ]  No [ ]  UnknownDid the patient have another diagnosis/etiology for their illness?[ ]  Yes [ ]  No [ ]  UnknownDid the patient have an abnormal chest x-ray?[ ]  Yes [ ]  No [ ]  Unknown |
| Did the patient die as a result of this illness? [ ]  Yes [ ]  No [ ]  UnknownDate of death: / / (MM/DD/YYYY) [ ]  Unknown |

|  |
| --- |
| Is the patient a healthcare worker in the United States? [ ]  Yes [ ]  No [ ]  UnknownIs this person associated with a day care facility? [ ]  Yes [ ]  No [ ]  UnknownIs this person a food handler? [ ]  Yes [ ]  No [ ]  Unknown[ ]  Travel to other non-US country specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Household contact with another lab- confirmed COVID-19 case-patient[ ]  Community contact with another lab-confirmed COVID-19 case-patient [ ]  Any healthcare contact with another lab-confirmed COVID-19 case-patient [ ]  Patient [ ]  Visitor [ ]  HCW [ ]  Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology [ ]  Animal exposure[ ]  Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  UnknownIf the patient had contact with another COVID-19 case, was this person a U.S. case? [ ]  Yes, nCoV ID of source case: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  No [ ]  Unknown [ ]  N/A |
| Under what process was the case first identified? (check all that apply): [ ]  Clinical evaluation leading to PUI determination [ ]  Contact tracing of case patient [ ]  Routine surveillance [ ]  EpiX notification of travelers; if checked, DGMQID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Unknown [ ]  Other, specify:\_\_\_\_\_\_\_\_\_\_ |

Were symptoms present during the course of illness: [ ]  Yes [ ]  No [ ]  Unknown

**Symptom Onset Date (Contact Tracing Start)**

Determine date and time of onset of the first COVID-19-related symptom (e.g., elevated body temperature or subjective fever, cough, or shortness of breath). For the purposes of contact tracing, go back 48 hours from the time of first symptom onset and use this as the start time for the period during which the patient was infectious and could have transmitted the virus.

**Onset Date:** \_\_/\_\_\_/\_\_\_Time: \_\_\_:\_\_\_\_ € AM € PM[ ]  Unknown **Start Date**: \_\_/\_\_\_/\_\_\_\_ Time: \_\_:\_\_\_\_ € AM € PM

If symptomatic, date of symptom resolution:

 / / (MM/DD/YYYY) [ ]  Still symptomatic [ ]  Symptoms resolved, unknown date [ ]  Unknown status

**Isolation Start (Contact Tracing End)**

Determine the date/time when the person was isolated at a healthcare facility or at home. The end date for the infectiousness period can be determined by 1) two negative tests in a row, 24 hours apart with improved symptoms and no fever or 2) when the person has been fever free for at least 72 hours, other symptoms have improved, and at least 7 days have passed since your symptoms first appeared.

**End Date**: \_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_:\_\_\_\_\_\_ € AM € PM [ ]  Still symptomatic and not hospitalized

1. Have you experienced any of the following symptoms?

| **Symptom** | **Symptom Present?** | **Date of Onset (MM/DD/YYYY)** | **Duration (no. of days)**  |
| --- | --- | --- | --- |
| Fever >100.4F (38C) | [ ] Yes [ ] No [ ] Unk |  |  |
| Subjective fever (felt feverish) | [ ] Yes [ ] No [ ] Unk |  |  |
| Chills | [ ] Yes [ ] No [ ] Unk |  |  |
| Muscle aches (myalgia) | [ ] Yes [ ] No [ ] Unk |  |  |
| Runny nose (rhinorrhea) | [ ] Yes [ ] No [ ] Unk |  |  |
| Sore throat | [ ] Yes [ ] No [ ] Unk |  |  |
| Cough (new onset or worsening of chronic cough) | [ ] Yes [ ] No [ ] Unk |  |  |
| Shortness of breath (dyspnea) | [ ] Yes [ ] No [ ] Unk |  |  |
| Nausea/Vomiting | [ ] Yes [ ] No [ ] Unk |  |  |
| Headache | [ ] Yes [ ] No [ ] Unk |  |  |
| Abdominal pain | [ ] Yes [ ] No [ ] Unk |  |  |
| Diarrhea (≥3 loose/looser than normal stools/24hr period) | [ ] Yes [ ] No [ ] Unk |  |  |
| Other, specify:  | [ ] Yes [ ] No [ ] Unk |  |  |

1. Do you have any pre-existing medical conditions? [ ]  Yes [ ]  No [ ]  Unknown

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Chronic Lung Disease (asthma/emphysema/COPD) | [ ] Yes | [ ] No | [ ] Unknown |  |
| Diabetes Mellitus  | [ ] Yes | [ ] No | [ ] Unknown |  |
| Severe obesity (BMI ≥40) | [ ] Yes | [ ] No | [ ] Unknown |  |
| Cardiovascular disease | [ ] Yes | [ ] No | [ ] Unknown |  |
| Chronic Renal disease | [ ] Yes | [ ] No | [ ] Unknown |  |
| Chronic Liver disease | [ ] Yes | [ ] No | [ ] Unknown |  |
| Immunocompromised Condition | [ ] Yes | [ ] No | [ ] Unknown |  |
| Neurologic/neurodevelopmental disorder | [ ] Yes | [ ] No | [ ] Unknown | (If YES, specify)  |
| Other chronic diseases | [ ] Yes | [ ] No | [ ] Unknown | (If YES, specify)  |
| If female, pregnant | [ ] Yes | [ ] No | [ ] Unknown |  |
| Current smoker | [ ] Yes | [ ] No | [ ] Unknown |  |
| Former smoker | [ ] Yes | [ ] No | [ ] Unknown |  |

1. Respiratory Diagnostic Testing- What testing has been performed?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Test | Pos | Neg | Pend. | Not Done |
| Influenza rapid Ag [ ]  A [ ]  B | [ ]  | [ ]  | [ ]  | [ ]  |
| Influenza PCR [ ]  A [ ]  B | [ ]  | [ ]  | [ ]  | [ ]  |
| RSV | [ ]  | [ ]  | [ ]  | [ ]  |
| H. metapneumovirus | [ ]  | [ ]  | [ ]  | [ ]  |
| Parainfluenza (1-4) | [ ]  | [ ]  | [ ]  | [ ]  |
| Adenovirus | [ ]  | [ ]  | [ ]  | [ ]  |
| Rhinovirus/enterovirus | [ ]  | [ ]  | [ ]  | [ ]  |
| Coronavirus (OC43, 229E, HKU1, NL63) | [ ]  | [ ]  | [ ]  | [ ]  |
| M. pneumoniae | [ ]  | [ ]  | [ ]  | [ ]  |
| C. pneumoniae | [ ]  | [ ]  | [ ]  | [ ]  |
| Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  | [ ]  | [ ]  | [ ]  |

1. Specimens for COVID-19 Testing (Interviewer to complete)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Specimen Type | Specimen ID | Date Collected | State Lab Tested | State Lab Result | Sent to CDC | CDC Lab Result |
| NP Swab |  |  | [ ]  |  | [ ]  |  |
| OP Swab |  |  | [ ]  |  | [ ]  |  |
| Sputum |  |  | [ ]  |  | [ ]  |  |
| Other,Specify:\_\_\_\_\_\_\_\_ |  |  | [ ]  |  | [ ]  |  |
|
|
|

## Step 3: Contact Tracing

Use this form to record the confirmed or suspected case-patient’s activities and potential close contacts from **48 hours before the first symptom onset (“start” date/time)** until **placement in appropriate isolation or end of infectious period (“end” date/time)**. If names and locator information for contacts are not immediately available, describe setting and (if possible), and provide contact information for facility managers or others who may be able assist with names of contacts.

Record the names and contact information for community and healthcare contacts on the provided line lists and make additional copies as necessary.

**Activity history beginning on the day of symptom onset**

*I am going to ask you to think back over each day while you have been sick to remember what you did each day. This will help us figure out who you may have been around, and who else might get sick. If you are having a hard time remembering, sometimes it is helpful to look back at a calendar, or on your phone for messages sent on each day, or even at your credit card receipts.*

Please list all activities, places visited, and travel you participated in starting 48 hours before the day of your first symptom.

From: \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ THROUGH: date of isolation or date at the end of estimated infectious period (Day 7 or 3 days after feeling afebrile and well, whichever is longer) : \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

Questions to assist- *Where did you wake up this morning? Did you go to work or school this day? What is your work or school environment like? What is your normal work or school day like? Who lives with you? Did you have any visitors? Who did you eat your meals with? Did you have any outings or social gatherings? Did you ride on public transportation or in a ride-share? Did you have any appointments?*

Copy this page if today is >14 days after symptom onset to assess case-patient’s activities for entirety of infectious period.

|  |  |  |  |
| --- | --- | --- | --- |
|  | AM Events/Locations | PM Events/Locations | Notes |
| 48 hours before date of illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| 24 hours before date of illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| Date of illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| 1 day after illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| 2 day after illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| 3 day after illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| 4 day after illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| 5 day after illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| 6 day after illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| 7 day after illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| 8 day after illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| 9 day after illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| 10 day after illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| 11 day after illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| 12 day after illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| 13 day after illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |
| 14 day after illness onset:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |  |  |  |

**Potential healthcare-related contacts by location and type of interaction**

**Healthcare contact** includes contacts from any healthcare-related encounter while the person was symptomatic or asymptomatic (within 7 days before onset of symptoms). Consider:

1. **Hospital contact:** where patient is hospitalized, isolated and being treated. These persons will have ongoing exposures as they continue to provide care for the patient and includes healthcare workers, laboratorians, persons who clean the room of the patient, ancillary staff, and funeral staff or others handling the body of the deceased patient.
2. **Others**: which includes all other persons with occupational exposures to the patient or his/her body fluids, including in other healthcare settings (e.g., physician office, dentist office, outpatient clinic, urgent care center, during transport/EMS) before the patient was diagnosed, isolated and treated; these contacts might have had exposure to the patient in a healthcare setting other than the one providing ongoing care for the patient).
3. Copy this page if more space is needed to record potential close contacts.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| # | Name(Last name, First name) | Sex (M/F)  | Age (years) | Role (pt care, EMS, lab worker, EVS, dietary, etc.) | Name of Hospital/Facility/Office  | Last contact date  | Shift Time | Phone number | Email | Description of interaction |
| 1 |  |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |  |  |

Notes:

**Potential community close contacts by location and type of interaction**

Community contact: includes those from the household or other community settings and does not include healthcare workers. Consider:

1. **Household/intimate contacts**: person(s) who resided in the same household as the patient or who visited or cared for the patient at home; person(s) who kissed, had sex with, or slept in the same bed as the case-patient; person(s) who shared eating or drinking utensils; person(s) who provided care (e.g., with bathing, toileting, dressing or feeding), cleaned the potentially contaminated environment, and those who might have had contact with the case-patient’s blood or body fluids. Include dormitory, group home, or other facility where bedrooms, bathrooms, kitchens, or other common areas are shared.
2. **Others**: Include close contacts from outside the home
3. Copy this page if more space is needed to record potential close contacts.
4. For Priority contact (last column), refer to Prioritization for VDH Resources.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| # | Name(Last name, First name) | Sex (M/F)  | Age (years) | Relationship to case-patient | Last contact date | Street address | City, State | Phone number/Email | Description of interaction | Consent to share your name? | Priority contact? |
| 1 |  |  |  |  |  |  |  |  |  |  Y N |  Y N |
| 2 |  |  |  |  |  |  |  |  |  | Y N | Y N |
| 3 |  |  |  |  |  |  |  |  |  | Y N | Y N |
| 4 |  |  |  |  |  |  |  |  |  | Y N | Y N |
| 5 |  |  |  |  |  |  |  |  |  | Y N | Y N |
| 6 |  |  |  |  |  |  |  |  |  | Y N | Y N |
| 7 |  |  |  |  |  |  |  |  |  | Y N | Y N |
| 8 |  |  |  |  |  |  |  |  |  | Y N | Y N |

Notes:

## Final Message

*Thank you so much for your assistance providing this information.*

*Again, we ask that you please* ***stay home and separate yourself from others****. Most people who get COVID-19 will recover without needing medical care. If you are at a higher risk of getting very sick, call your healthcare provider. If you experience emergency signs (e.g., difficulty breathing, pain or pressure in the chest that does not go away, new confusion or inability to arouse, or blueish lips or face), seek emergency medical care immediately by dialing 911.*

*Please remind those that you live with, intimate with, caring for you, or other close contacts that they should closely monitor their symptoms by taking their temperature twice a day (in the morning and at night) and watch for cough, and difficulty breathing.*

*Keep in mind, you can return to your normal activities at least 7 days after you became ill, and after feeling well, and without fever, for at least 3 days in a row*

*I know this is a long time to stay at home…let’s talk through some barriers you might face during this time…*

 *Do you have someone that can take care of you while you’re sick?*

 *Do you know how to take care of yourself (over the counter medication, etc.)*

*Do you have a facemask at home with you?*

*What do you do for work? Is it possible to work from home during this time?*

 *Who else lives in your household? Are any household members at a higher risk for getting very sick from COVID-19?*

 *Do you have someone that could run errands/get groceries for you?*

*Do you have any additional questions? Please visit our website* [*www.vdh.virginia.gov/coronavirus/coronavirus/what-to-do-if-you-have-confirmed-or-suspected-coronavirus-disease-covid-19/*](http://www.vdh.virginia.gov/coronavirus/coronavirus/what-to-do-if-you-have-confirmed-or-suspected-coronavirus-disease-covid-19/) *and feel free to call our number at \_\_\_\_\_\_\_ at any time for questions about recovering or any other COVID-19 concerns. Please leave a message if no one answers, and expect a return call by the next business day.*

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