Novel Coronavirus COVID-19 Case Report

Michigan Department of Health and Human Services

Communicable Disease Division

Investigation Information

Investigation ID	Onset Date *(mm/dd/yyyy)*	Diagnosis Date *(mm/dd/yyyy)*	Referral Date *(mm/dd/yyyy)*	Case Entry Date *(mm/dd/yyyy)*	Case Completion Date *(mm/dd/yyyy)*

Investigation Status	Case Status	
Active	○ Confirmed ○ Confirmed - Non Resident ○ Not a Case ○ Probable ○ Suspect ○ Unknown ○ Non-Michigan Case	☐ State Prison Case

Patient Status	Patient Status Date *(mm/dd/yyyy)*	Case Disposition	Case Updated Date *(mm/dd/yyyy)*
Alive			

CDC/MI-nCoV-ID	Report date of case to CDC *(mm/dd/yyyy)*	State of residence	County of residence

Patient Information

Patient ID	First	Last	Middle

Street Address

City	County	State	Zip

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.

Parent/Guardian (required if under 18)

First	Last	Middle

Demographics

Sex	Date of Birth *mm/dd/yyyy*	Age	Age Units
○ Male ○ Female ○ Unknown			○ Days ○ Months ○ Years

Race *(Check all that apply)*

☐ Caucasian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Asian ☐ Unknown

☐ Other (Specify)

Hispanic Ethnicity	Arab Ethnicity
○ Hispanic/Latino ○ Non-Hispanic/Latino ○ Unknown	○ Arab ○ Non-Arab ○ Unknown

Worksites/School	Occupations/Grade	MDOC ID

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Referral Information

Person Providing Referral			
First	Last	Phone ###-###-#### Ext.	Email
Primary Physician			
First	Last	Phone ###-###-#### Ext.	Email
Street Address			
City	County	State	Zip

Hospital Information

Patient Hospitalized ○ Yes ○ No ○ Unknown	Hospital	Hospital City	Hospital Record No.
Admission Date *(mm/dd/yyyy)*	Discharge Date *(mm/dd/yyyy)*	Days Hospitalized	Patient Admitted to ICU ○ Yes ○ No ○ Unknown
Symptoms present during course of illness? ○ Yes ○ No ○ Unknown	Is/was the patient isolated in the hospital? ○ Yes ○ No ○ Unknown	Hospital isolation start date *(mm/dd/yyyy)*	Hospital isolation end date *(mm/dd/yyyy)*
Did the patient receive mechanical ventilation(MV)/intubation? ○ Yes ○ No ○ Unknown	Did the patient receive ECMO? ○ Yes ○ No ○ Unknown	Patient Died ○ Yes ○ No ○ Unknown	Date of Death *(mm/dd/yyyy)*

Clinical Information

Information on signs and symptoms			
Fever (subjective or measured) ○ Yes ○ No ○ Unknown	If yes, specify highest temperature	Scale ○ Fahrenheit ○ Celsius	Chills/rigors ○ Yes ○ No ○ Unknown
Muscle aches (myalgia) ○ Yes ○ No ○ Unknown	Runny nose (rhinorrhea) ○ Yes ○ No ○ Unknown	Sore Throat ○ Yes ○ No ○ Unknown	Cough (new onset or worsening of chronic) ○ Yes ○ No ○ Unknown
Shortness of breath (dyspnea) ○ Yes ○ No ○ Unknown	Nausea or vomiting ○ Yes ○ No ○ Unknown	Headaches ○ Yes ○ No ○ Unknown	Abdominal pain ○ Yes ○ No ○ Unknown
Diarrhea (≥3 loose/looser than normal stools/24hr period) ○ Yes ○ No ○ Unknown	Fatigue/Lethargy/Weakness ○ Yes ○ No ○ Unknown	Congestion (Coryza) ○ Yes ○ No ○ Unknown	Encephalopathy/Encephalitis ○ Yes ○ No ○ Unknown
Evidence of Pneumonia ○ Yes ○ No ○ Unknown	Confirmatory Chest X-ray or CAT scan for Pneumonia ○ Positive ○ Negative ○ Not Done ○ Unknown		Seizure ○ Yes ○ No ○ Unknown
Multi-organ Dysfunction Syndrome (MODS) ○ Yes ○ No ○ Unknown	Acute Respiratory Distress Syndrome (ARDS) ○ Yes ○ No ○ Unknown	Toxic state (Sepsis) ○ Yes ○ No ○ Unknown	
Other clinical signs			

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Epidemiologic Information

Health care worker in the United States? ○ Yes ○ No ○ Unknown	If yes, please specify facility:	Any healthcare contact with a COVID-19 lab-confirmed case-patient? ○ Yes ○ No ○ Unknown
Household contact to a COVID-19 lab-confirmed case-patient? ○ Yes ○ No ○ Unknown		Community contact to a COVID-19 lab-confirmed case-patient? ○ Yes ○ No ○ Unknown

Travel to mainland China? ○ Yes ○ No ○ Unknown	If Yes, Date of Arrival *(mm/dd/yyyy)*	Date of Departure *(mm/dd/yyyy)*

Travel to other non-U.S. country? ○ Yes ○ No ○ Unknown

If Yes, *List all travels to non-U.S. countries*

Country	Date of Arrival *(mm/dd/yyyy)*	Date of Departure *(mm/dd/yyyy)*

Travel to states and U.S. cities outside of home state? ○ Yes ○ No ○ Unknown

If Yes, *List all travels to states and U.S. cities*

U.S. States	U.S. Cities	Date of Arrival *(mm/dd/yyyy)*	Date of Departure *(mm/dd/yyyy)*

Travel within Michigan? ○ Yes ○ No ○ Unknown	If Yes, Location:	Date of Arrival *(mm/dd/yyyy)*	Date of Departure *(mm/dd/yyyy)*

Information on pre-existing conditions *(Check all that apply)*

☐ Asthma/Reactive Airway Disease ☐ Cardiovascular Disease ☐ Cancer ☐ Chronic Lung Disease/COPD/Emphysema
☐ Diabetes Mellitus ☐ Neurologic Disease ☐ Chronic Liver Disease ☐ Chronic Renal Disease
☐ Other Immunosuppressive Condition (Specify) ☐ Other Chronic Disease (Specify)

Was the patient receiving any of the following medications when the illness started? *(Check all that apply)*

☐ Aspirin or aspirin-containing products ☐ Chemotherapy ☐ Radiation therapy ☐ Systemic steroids (not inhaled)
☐ Other immunosuppressive medications (Specify) ☐ Unknown

If female, Was patient pregnant at the time of the event? ○ Yes ○ No ○ Unknown	If patient pregnant, specify gestational age:	If patient pregnant, define gestational age units: ○ Days ○ Months ○ Weeks

Current Smoker? ○ Yes ○ No ○ Unknown	Former Smoker? ○ Yes ○ No ○ Unknown
Current vape user? ○ Yes ○ No ○ Unknown	Former vape user? ○ Yes ○ No ○ Unknown

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Contact Information

Name of Contact	Age	Onset Date *(mm/dd/yyyy)*	Relation	Flu-like symptoms?	Quarantined?	Contact Information

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Other Information

Local 1	Local 2

Name of Person interviewed	Relationship to patient	Date of interview *mm/dd/yyyy*

Submitted by:	Date *mm/dd/yyyy*	Health Department	Phone Number ###-###-####	Ext.

Comments or Additional Information

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Case Notes

Notes

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Lab Results

Report Date	Test Name	Reported Test Name/Test Result	Specimen	Collection Date
(mm/dd/yyyy)				*(mm/dd/yyyy)*
No Labs				