**Form A1: CASE initial reporting form – for confirmed COVID-19 cases (Day 1)**

Unique Case ID/Cluster number (if applicable):

| |
|---|
| |

| 1. Current status |
|---|
| □ Alive □ Dead □ Unknown/lost to follow-up |
| 2. Further case classification |
| □ Primary □ Secondary □ Imported |

| 3. Data collector information | |
|---|---|
| Name of data collector | |
| Data collector institution | |
| Data collector telephone number | |
| Data collector email | |
| Form completion date (mm/dd/yyyy) | ___/___/___ |

| 4. Interview respondent information (if the person providing the information is not the patient) | |
|---|---|
| First name | |
| Family name | |
| Sex | □ Male □ Female □ Not known |
| Date of birth (mm/dd/yyyy) | ___/___/___<br>□ Unknown |
| Relationship to patient | |
| Respondent address | |
| Telephone (mobile) number | |

| 5. Patient identifier information | |
|---|---|
| First name | |
| Family name | |
| Sex | □ Male □ Female □ Not known |
| Date of birth (mm/dd/yyyy) | ___/___/___<br>□ Unknown |
| Telephone (mobile) number | |
| Age (years, months) | ___ years ___ months □ Unknown |
| Email | |
| Address | |

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| | |
|---|---|
| National social number/identifier (if applicable) | |
| Country of residence | |
| Nationality | |
| Patient occupation (specify location/facility) | □ Health care worker<br>□ Working with animals<br>□ Health laboratory worker<br>□ Student<br>□ Other, specify:<br><br>For each occupation, please specify location or facility:______________________________________ |
| Ethnicity | |
| Responsible health center | |
| Nursery/school/college if appropriate | |

| 6. Health-care center/treating physician's details | |
|---|---|
| Name of health-care center | |
| Name of treating physician | |
| Is this case part of an institutional outbreak? | □ Yes □ No □ Unknown<br>If Yes, specify: |
| Telephone number | |
| Fax | |
| Address | |

| 7a. Patient symptoms (from onset of symptoms) | |
|---|---|
| Date of first symptom onset (mm/dd/yyyy) | ___/___/___<br>□ No symptoms □ Unknown |
| Fever (≥100.4 °F) or history of fever | □ Yes □ No □ Unknown<br>If Yes, specify maximum temperature: °F |
| Date of first health facility visit (including traditional care) (mm/dd/yyyy) | ___/___/___<br>□ Not applicable (na) □ Unknown |
| Total health facilities visited to date | □ na □ Unknown<br>Specify: |
| 7b. Respiratory symptoms **(within the last 14 days)** | |
| Sore throat | □ Yes □ No □ Unknown<br>If Yes, date (mm/dd/yyyy): ___/___/___ |
| Runny nose | □ Yes □ No □ Unknown |
| Cough | □ Yes □ No □ Unknown<br>If Yes, date (mm/dd/yyyy): ___/___/___ |

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| Shortness of breath | □ Yes □ No □ Unknown<br>If Yes, date (mm/dd/yyyy): ___/___/___ |
|---|---|
| 7c. Other symptoms **(within the last 14 days)** | |
| Loss of smell or taste | □ Yes □ No □ Unknown |
| Chills | □ Yes □ No □ Unknown |
| Vomiting | □ Yes □ No □ Unknown |
| Nausea | □ Yes □ No □ Unknown |
| Diarrhoea | □ Yes □ No □ Unknown |
| Headache | □ Yes □ No □ Unknown |
| Rash | □ Yes □ No □ Unknown |
| Conjunctivitis | □ Yes □ No □ Unknown |
| Muscle aches | □ Yes □ No □ Unknown |
| Joint ache | □ Yes □ No □ Unknown |
| Loss of appetite | □ Yes □ No □ Unknown |
| Nose bleed | □ Yes □ No □ Unknown |
| Fatigue | □ Yes □ No □ Unknown |
| Seizures | □ Yes □ No □ Unknown |
| Altered consciousness | □ Yes □ No □ Unknown |
| Other neurological signs | □ Yes □ No □ Unknown<br>If Yes, specify: |
| Other symptoms | □ Yes □ No □ Unknown<br>If Yes, specify: |

| 8. Patient symptoms: complications | |
|---|---|
| Hospitalization | □ Yes □ No □ Unknown |
| Date of first hospitalization (mm/dd/yyyy) | ___/___/___ □<br>Unknown |
| ICU (intensive care unit) admission | □ Yes □ No □ Unknown |
| Date of ICU admission (mm/dd/yyyy) | ___/___/___ □<br>Unknown |
| Date of discharge from ICU (mm/dd/yyyy) | ___/___/___<br>□ Unknown □ na |
| Mechanical ventilation | □ Yes □ No □ Unknown |
| Dates of mechanical ventilation (mm/dd/yyyy) | Start:___/___/___ Stop:<br>___/___/___<br>□ Unknown □ na |
| Length of ventilation (days) | |
| Acute respiratory distress syndrome (ARDS) | □ Yes □ No □ Unknown<br>If Yes, date started (mm/dd/yyyy)___/___/___ |

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| | |
|---|---|
| Acute renal failure | □ Yes □ No □ Unknown<br>If Yes, date started (mm/dd/yyyy)___/___/___ |
| Cardiac failure | □ Yes □ No □ Unknown<br>If Yes, date started (mm/dd/yyyy)___/___/___ |
| Consumptive coagulopathy | □ Yes □ No □ Unknown<br>If Yes, date started (mm/dd/yyyy)___/___/___ |
| Pneumonia by chest X-ray | □ Yes □ No □ Unknown<br>If Yes, date started (mm/dd/yyyy) ___/___/___ |
| Other complications | □ Yes □ No □ Unknown<br>If Yes, specify: |
| Hypotension requiring vasopressors | □ Yes □ No □ Unknown |
| Extracorporeal membrane oxygenation (EMO) required | □ Yes □ No □ Unknown |

| | |
|---|---|
| Date of discharge from hospital (if applicable) (mm/dd/yyyy) | ___/___/___ |
| Outcome | □ Alive □ Dead □ na □ Unknown |
| Outcome current as of date (mm/dd/yyyy) | ___/___/___<br>□ Unknown □ na |

| 9. Patient pre-existing condition(s) | |
|---|---|
| Pregnancy | □ Yes □ No □ Unknown<br>If Yes, specify trimester:<br>□ First □ Second □ Third □ Unknown |
| Obesity | □ Yes □ No □ Unknown |
| Cancer | □ Yes □ No □ Unknown |
| Diabetes | □ Yes □ No □ Unknown |
| HIV/other immune deficiency | □ Yes □ No □ Unknown |
| Heart disease | □ Yes □ No □ Unknown |
| Asthma (requiring medication) | □ Yes □ No □ Unknown |
| Chronic lung disease (non-asthma) | □ Yes □ No □ Unknown |
| Chronic liver disease | □ Yes □ No □ Unknown |
| Chronic haematological disorder | □ Yes □ No □ Unknown |
| Chronic kidney disease | □ Yes □ No □ Unknown |
| Chronic neurological impairment/disease | □ Yes □ No □ Unknown |
| Organ or bone marrow recipient | □ Yes □ No □ Unknown |
| Other pre-existing condition(s) | □ Yes □ No □ Unknown<br>If Yes, specify: |

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| 10. Health-care interactions | |
|---|---|
| Contact with emergency number/ hotline | □ Yes □ No □ Unknown |
| Date of emergency contact (mm/dd/yyyy) | ___/___/___ □ Unknown |
| Visit to primary healthcare (PHC; GP, etc.) (repeat for as many visits as required) | □ Yes □ No □ Unknown |
| Date of first PHC contact (mm/dd/yyyy) | ___/___/___ □ Unknown □ na |
| Visited emergency department (A&E) (repeat for as many contacts as required) | □ Yes □ No □ Unknown |
| Date of first A&E contact (mm/dd/yyyy) | ___/___/___ □ Unknown □ na |
| Hospitalization (repeat for as many admissions as required) | □ Yes □ No □ Unknown |
| Date of admission to hospital (mm/dd/yyyy) | ___/___/___ □ Unknown □ na |
| Name and place of hospital | |

| 11. Human exposures in the days before symptom onset (as of February 2020, in the past 14 days) | |
|---|---|
| Have you travelled within the last 14 days domestically? | □ Yes □ No □ Unknown<br>If Yes, dates of travel (mm/dd/yyyy):<br>___/___/___ to ___/___/___<br><br>Regions visited:<br><br>Cities visited: |

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| | |
|---|---|
| Have you travelled within the last 14 days internationally? | □ Yes □ No □ Unknown<br>If Yes, dates of travel (mm/dd/yyyy):<br>___/___/___ to ___/___/___<br><br>Countries visited:<br><br>Cities visited: |
| In the past 14 days, have you had contact with anyone with suspected or confirmed COVID-19 infection? | □ Yes □ No □ Unknown<br>If Yes, dates of last contact (mm/dd/yyyy):<br>___/___/___ |
| Patient attended festival or mass gathering in the past 14 days (e.g., church, family/social gathering, party, rosary, etc.) | □ Yes □ No □ Unknown<br>If Yes, specify: |
| Patient exposed to person with similar illness in the past 14 days | □ Yes □ No □ Unknown |
| Location of exposure in the past 14 days | □ Home □ Hospital □ Workplace<br>□ Tour group □ School □<br>Unknown □ Other, specify: |
| Patient visited or was admitted to inpatient health facility in the past 14 days | □ Yes □ No □ Unknown<br>If Yes, specify: |
| Patient visited outpatient treatment facility in the past 14 days | □ Yes □ No □ Unknown<br>If Yes, specify: |
| Patient visited traditional healer in the past 14 days | □ Yes □ No □ Unknown<br>If Yes, specify type: |
| Patient occupation (specify location/facility) | □ Health worker<br>□ Working with animals<br>□ Health laboratory worker<br>□ Student<br>□ Other, specify:<br><br>For each occupation, please specify location or facility: |

**Form A1: CASE initial reporting form – for confirmed COVID-19 cases (Day 1)**

| 12a. Molecular testing methods and results: | | | | | | | |
|---|---|---|---|---|---|---|---|
| Complete a new line for each specimen collected and each type of test done: | | | | | | | |
| Laboratory identification number | Date sample collected (mm/dd/yyyy) | Date sample received (mm/dd/yyyy) | Type of sample | Type of test | Result | Result date (mm/dd/yyyy) | Specimens shipped to other laboratory for confirmation |
| | ___/___/___ | ___/___/___ | □ Nasal swab<br>□ Throat swab<br>□ Nasopharyngeal swab<br>□ Other, specify: | □ PCR<br>□ Whole genome sequencing □ Par al genome sequencing<br>□ Other, specify | □ POSITIVE for COVID-19<br>□ NEGATIVE for COVID19<br>□ POSITIVE for other pathogens<br>Please specify which pathogens: | ___/___/___ | □ Yes<br>If Yes, specify date ___/___/___<br>If Yes, name of the laboratory: ____<br>□ No |

| 12b. Serology testing methods and results: | | | | | | | |
|---|---|---|---|---|---|---|---|
| Complete a new line for each specimen collected and each type of test done: | | | | | | | |
| Laboratory identification number | Date sample collected (mm/dd/yyyy) | Date sample received (mm/dd/yyyy) | Type of sample | Type of test | Result (COVID-19 antibody titres) | Result date (mm/dd/yyyy) | Specimens shipped to other laboratory for confirmation |
| | ___/___/___ | ___/___/___ | □ Serum<br>□ Other, specify: | Specify type (ELISA/IFA IgM/IgG, neutralization assay, etc.): | □ POSITIVE<br>If positive, titre:<br>□ NEGATIVE<br>□ INCONCLUSIVE | ___/___/___ | □ Yes<br>If Yes, specify date ___/___/___ If Yes, name of the laboratory: ____<br>□ No |

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| 13. Status of form completion | |
|---|---|
| Form completed | □ Yes □ No or partially<br><br>If No or partially, reason:<br>□ Missed<br>□ Not attempted<br>□ Not performed<br>□ Refusal<br>□ Other, specify: |
| ○ CONTACT ELICITATION LOG COMPLETED<br><br>○ SIGNIFICANT EVENTS / PLACES FREQUENTED SHEET COMPLETED | |