Form B1: CONTACT initial reporting form – for close contacts of confirmed cases (Day 1)

Name of confirmed case

Confirmed Case ID/Cluster number (if applicable):

Contact ID Number (C…):
Note: Contact ID numbers should be issued at the time of completion of Form A1.

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

2. Interview respondent information (if the persons providing the information is not the contact)	
First name	
Family name	
Sex	□ Male □ Female □ Not known
Date of birth (mm/dd/yyyy)	___/___/___ □ Unknown
Relationship to patient	
Respondent address	
Telephone (mobile) number	

3. Contact details (details of the contact)	
First name	
Family name	
Sex	□ Male □ Female □ Not known
Date of birth (mm/dd/yyyy)	___/___/___ □ Unknown
Relationship to case	
Address (village/town, district, province/region)	
Telephone (mobile) number	
Email	
Preferred mode of contact	□ Mobile □ Work □ Home □ Email

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Nationality	
Country of residence	
National social number/identifier (optional)	
Ethnicity (optional)	

4. General exposure information	
Have you travelled within the last 14 days domestically?	□ Yes □ No □ Unknown If Yes, dates of travel (mm/dd/yyyy): ___/___/___ to ___/___/___ Regions visited: Cities visited:
Have you travelled within the last 14 days internationally?	□ Yes □ No □ Unknown If Yes, dates of travel (mm/dd/yyyy): ___/___/___ to ___/___/___ Countries visited: Cities visited:
In the past 14 days, have you had contact with anyone with suspected or confirmed COVID-19 infection?	□ Yes □ No □ Unknown If Yes, dates of last contact (mm/dd/yyyy): ___/___/___
Occupation (specify location/facility)	□ Health worker □ Working with animals □ Health laboratory worker □ Student □ Other, specify: For each occupation, please specify location or facility:

Note for next 2 sections:

- Complete Section 5 if the contact is a health worker (HW).
- Complete Section 6 if the contact is NOT a health worker.

5. Exposure information (if the close contact is a Health Worker (HW))	
Job title (specify)	
Place of work	

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Direct physical contact with the confirmed case (e.g. hands-on physical contact)	□ Yes □ No

Has the HW had prolonged face-to-face contact (>15 minutes) with a symptomatic confirmed case in a health facility? (Add as many procedures and their dates as required)	□ Yes □ No If Yes, what type of protective equipment was used by the HW? □ Gown □ Gloves □ Eye protection □ Surgical/medical mask □ NIOSH-certified N95 or an EU standard FFP2 mask □ FFP3 mask
Has the HW had prolonged face-to-face contact (>15 minutes) with an asymptomatic confirmed case in a health facility? (Add as many procedures and their dates as required)	□ Yes □ No If Yes, what type of personal protective equipment (PPE) was used by the HW? □ Gown □ Gloves □ Eye protection □ Surgical/medical mask □ NIOSH-certified N95, an EU standard FFP2 mask □ FFP3 mask
Was the contact present while any aerosol-generating procedures took place?	□ Yes □ No If Yes, specify procedure and date (mm/dd/yyyy) Procedure: ___/___/___ Procedure: ___/___/___ Was the contact wearing any type of a mask at this/these procedures? □ Surgical/medical mask □ NIOSH-certified N95, an EU standard FFP2 mask □ FFP3 mask □ None

6. Exposure information (if the close contact is NOT a Health W)		
Type of contact	□ Household □ Other, specify:	
Specify characteristics of contact with the confirmed case from first contact, while the primary case was symptomatic	Date (mm/dd/yyyy)	__/__/__
	Duration	_____(minutes)

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(Add as many dates as required)	Setting	□ Home/household □ Hospital/health care □ Workplace □ Tour group □ Other,specify:
Specify characteristics of contact with the confirmed case from first contact, while the primary case was asymptomatic (Add as many dates as required)	Date (mm/dd/yyyy)	__/__/__
	Duration	_____(minutes)
	Setting	□ Home/household □ Hospital/health care □ Workplace □ Tour group □ Other, specify:

6a. Symptoms in contact	
Has the contact experienced any respiratory symptoms (sore throat, runny nose, cough, shortness of breath) in the period from 14 days before symptom onset in the confirmed case until the present?	□ Yes □ No
Has the contact experienced any respiratory symptoms (sore throat, runny nose, cough, shortness of breath) in the period up to 14 days after the last contact or until the present date, whichever is the earlier?	□ Yes □ No
Currently ill	□ Yes □ No
Date (mm/dd/yyyy) and time of first symptom onset	___/___/___ □am □ pm
Fever (>100.4 °f) or history of fever	□ Yes □ No □ Unknown If Yes, date ___/___/___
Maximum temperature	°F □ Not applicable (na)
6b. Respiratory symptoms **(within the last 14 days)**	
Sore throat	□ Yes □ No □ Unknown If Yes, date ___/___/___
Runny nose	□ Yes □ No □ Unknown
Cough	□ Yes □ No □ Unknown If Yes, date ___/___/___
Shortness of breath	□ Yes □ No □ Unknown If Yes, date ___/___/___
6c. 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

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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 If Yes, specify:
Other symptoms	□ Yes □ No □ Unknown If Yes, specify:

7. Outcome/status of contact (only complete if contact has been ill or is currently ill)	
Status	□ Recovered, if Yes, specify date symptoms resolved (mm/dd/yyyy) ___/___/___ □ Still ill □ Dead, if Yes, specify date of death (mm/dd/yyyy) ___/___/___ □ Unknown/lost to follow-up
Hospitalization ever required?	□ Yes □ No □ Unknown If yes, date of hospitalization and date of discharge (mm/dd/yyyy) ___/___/___ to ___/___/___
(NB. If the information below is not currently available, please leave blank and send through an update as soon as results are available)	
If dead, contribution of COVID-19 to death:	□ Underlying/primary □ Contributing/secondary □ No contribution to death □ Unknown
If dead, was a postmortem performed?	□ Yes □ No □ Unknown
If dead, results of postmortem's report where available:	
If dead, cause of death on Death certificate (specify)	

8. Contact pre-existing condition(s)

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Pregnancy	□ Yes □ No □ Unknown If Yes, specify trimester: □ 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 If Yes, specify:
Comments if appropriate	

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9a. Virology 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 □ Throat swab □ Nasopharyngeal swab □ Other, specify:	□ PCR □ Whole genome sequencing □ Par al genome sequencing □ Other, specify	□ POSITIVE for COVID-19 □ NEGATIVE for COVID-19 □ POSITIVE for other pathogens Please specify which pathogens:	___/___/___	□ Yes If Yes, specify date ___/___/___ If Yes, name of the laboratory: □ No

9b. 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 □ Other, specify:	Specify type (ELISA/IFA IgM/IgG, neutralization assay, etc.):	□ POSITIVE If positive, titre: □ NEGATIVE □ INCONCLUSIVE	___/___/___	□ Yes If Yes, specify date ___/___/___ If Yes, name of the laboratory: ____ □ No

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10. Status of form completion	
Form completed	□ Yes □ No or partially If No or partially, reason: □ Missed □ Not attempted □ Not performed □ Refusal □ Other, specify: