Interim reporting form for suspected cases of COVID-19
(based on WHO Minimum Data Set Report Form)

Date of reporting to national health authority: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
Reporting institution: ________________________________
Detected at point of entry: No ☐ Yes ☐ Unknown ☐ If yes, date: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Section 1: Patient information

Unique case identifier (used at HF): ________________________________
Date of birth: [ ] [ ] [ ] [ ] [ ] [ ] [ ] or estimated age: [ ] [ ] [ ] in years
if < 1 year, [ ] [ ] in months or if < 1 month, [ ] [ ] in days
Sex at birth: ☐ Male ☐ Female
Patients’ usual place of residency: Country: ________________________________
Admin Level 1 (province): ________________________________ Admin Level 2 (district): ________________________________

Section 2: Clinical information

Patient clinical course
Date of onset of symptoms: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
Admission to hospital: No ☐ Yes ☐
First date of admission to hospital: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
Name of hospital: ________________________________
Date of isolation: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
Is the patient ventilated: No ☐ Yes ☐ Unknown ☐
Date of death, if applicable: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Patient symptoms (check all reported symptoms):
☐ History of fever / chills ☐ Shortness of breath ☐ Pain (check all that apply)
☐ General weakness ☐ Diarrhoea ( ) Muscular ( ) Chest
☐ Cough ☐ Nausea/vomiting ( ) Abdominal ( ) Joint
☐ Sore throat ☐ Headache
☐ Runny nose ☐ Irritability/Confusion
☐ Other, specify ________________________________

Patient signs:
Temperature: [ ] [ ] [ ] [ ] [ ] °C / °F
Check all observed signs:
☐ Pharyngea exudate ☐ Coma ☐ Abnormal lung x-ray findings
☐ Conjuctival injection ☐ Dyspnea / tachypnea
☐ Seizure ☐ Abnormal lung auscultation
☐ Other, specify ________________________________
**Underlying conditions and comorbidity** (check all that apply):

- [ ] Pregnancy (trimester: __________)  
- [ ] Cardiovascular disease, including hypertension  
- [ ] Diabetes  
- [ ] Liver disease  
- [ ] Chronic neurological or neuromuscular disease  
- [ ] Other, specify: ____________

**Occupation:** (tick any that apply):

- [ ] Student  
- [ ] Working with animals  
- [ ] Health care worker  
- [ ] Health laboratory worker  
- [ ] Other, specify: ____________

Has the patient travelled in the 14 days prior to symptom onset?  

- [ ] No  
- [ ] Yes  
- [ ] Unknown

If yes, please specify the places the patient travelled:

<table>
<thead>
<tr>
<th>Country</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has the patient visited any health care facility(ies) in the 14 days prior to symptom onset?  

- [ ] No  
- [ ] Yes  
- [ ] Unknown

Has the patient had close contact\(^1\) with a person with acute respiratory infection in the 14 days prior to symptom onset?  

- [ ] No  
- [ ] Yes  
- [ ] Unknown

If yes, contact setting (check all that apply):

- [ ] Health care setting  
- [ ] Family setting  
- [ ] Work place  
- [ ] Unknown  
- [ ] Other, specify: ____________

Has the patient had contact with a probable or confirmed case in the 14 days prior to symptom onset?  

- [ ] No  
- [ ] Yes  
- [ ] Unknown

If yes, please list unique case identifiers of all probable or confirmed cases:

- Case 1 identifier. ____________  
- Case 2 identifier. ____________  
- Case 3 identifier. ____________

If yes, contact setting (check all that apply):

- [ ] Health care setting  
- [ ] Family setting  
- [ ] Work place  
- [ ] Unknown  
- [ ] Other, specify: ____________

If yes, location/city/country for exposure: ____________

Has you visited any live animal markets in the 14 days prior to symptom onset?  

- [ ] No  
- [ ] Yes  
- [ ] Unknown

If yes, location/city/country for exposure: ____________

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\(^1\) Close contact is defined as: 1. Health care associated exposure, including providing direct care for COVID-19 patients, working with health care workers infected with novel coronavirus, visiting patients or staying in the same close environment of a COVID-19 patient. 2. Working together in close proximity or sharing the same classroom environment with a with COVID-19 patient. 3. Traveling together with COVID-19 patient in any kind of conveyance. 4. Living in the same household as a COVID-19 patient.
Section 4: Laboratory information

<table>
<thead>
<tr>
<th>Samples collected</th>
<th>Date of Sample Collection (DD/MM/YYYY)</th>
<th>Date of Sample Sent (DD/MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasopharyngeal</td>
<td>☐ No ☑ Yes</td>
<td></td>
</tr>
<tr>
<td>Oropharyngeal (Throat)</td>
<td>☐ No ☑ Yes</td>
<td></td>
</tr>
<tr>
<td>Sputum</td>
<td>☐ No ☑ Yes</td>
<td></td>
</tr>
<tr>
<td>Endotracheal Aspirate</td>
<td>☐ No ☑ Yes</td>
<td></td>
</tr>
<tr>
<td>Bronchialveolar</td>
<td>☐ No ☑ Yes</td>
<td></td>
</tr>
<tr>
<td>Serum</td>
<td>☐ No ☑ Yes</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>☐ No ☑ Yes</td>
<td></td>
</tr>
</tbody>
</table>

If Other samples collected, specify ____________________________

Sample sent to
☒ NIC/NPHL   ☐ Others   If others, specify ____________________________

Any test conducted at HF / other laboratory for detection of pan-CoV

☒ No   ☐ Yes

If yes, please specify:

Details of test: ________________________________________________

Name of the laboratory conducted: ________________________________

Test results: ___________________________________________________