Government of Nepal
Ministry of Health and Population
Department of Health Services
Epidemiology and Disease Control Division

HF Case ID: _____

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

Date of reporting to national health authority: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Reporting institution: _____

Detected at point of entry ☐ No ☐ Yes ☐ Unknown If yes, date [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Section 1: Patient information

Unique case identifier (used at HF): _____

Date of birth: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] 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: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Admission to hospital: ☐ No ☐ Yes

First date of admission to hospital: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Name of hospital: _____

Date of isolation: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Is the patient ventilated: ☐ No ☐ Yes ☐ Unknown

Date of death, if applicable: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Patient symptoms (check all reported symptoms):

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

Patient signs :

Temperature: [ ][ ][ ] ☐ °C / ☐ F

Check all observed signs:

☐ Pharyngea exudate
☐ Conjuctival injection
☐ Seizure
☐ Coma
☐ Dyspnea / tachypnea
☐ Abnormal lung auscultation
☐ Abnormal lung x-ray findings
☐ 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 _____
- ☐ Post-partum (<6 weeks)
- ☐ Immunodeficiency, including HIV
- ☐ Renal disease
- ☐ Chronic lung disease
- ☐ Malignancy

Section 3: Exposure and travel information in the 14 days prior to symptom onset (prior to reporting if asymptomatic)

Occupation: (tick any that apply):

☐ Student ☐ Health care worker ☐ Other, specify: _____

☐ Working with animals ☐ Health laboratory worker

Has the patient **travelled** in the 14 days prior to symptom onset? ☐ No ☐ Yes ☐ Unknown

If yes, please specify the places the patient travelled:

	Country	City
1.	_____	_____
2.	_____	_____
3.	_____	_____

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] [1]with a person with acute respiratory infection in the 14 days prior to symptom onset?

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: _____

Have you visited any **live animal markets** in the 14 days prior to symptom onset? □ No □ Yes □ Unknown

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

[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

Samples collected		Date of Sample Collection (DD/MM/YYYY)	Date of Sample Sent (DD/MM/YYYY)
Nasopharyngeal	☐ No ☐ Yes		
Oropharyngeal (Throat)	☐ No ☐ Yes		
Sputum	☐ No ☐ Yes		
Endotracheal Aspirate	☐ No ☐ Yes		
Bronchioalveolar	☐ No ☐ Yes		
Serum	☐ No ☐ Yes		
Others	☐ No ☐ Yes		

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: _____