Revised case report form for Confirmed Novel Coronavirus COVID-19
(report to WHO within 48 hours of case identification)

Date of reporting to national health authority: [D][D]/[M][M]/[Y][Y][Y][Y]

Reporting country: ______________________________

Why tested for COVID-19:
☐ Contact of a case ☐ Ill Seeking Healthcare due to suspicion of COVID-19 ☐ Detected at point of entry ☐ Repatriation
☐ Routine respiratory disease surveillance systems (e.g. influenza) ☐ Unknown

If none of the above, please explain: ______________________________________________________________________________________

Section 1: Patient information

Unique Case Identifier (used in country): ______________________________

Age (years): [___][___][___]                  if <1 year old, [___][___] in months or if < 1 month, [___][___] in days

Sex at birth: ☐ Male        ☐ Female

Place where the case was diagnosed: Country: ______________________________

Admin Level 1 (province): ______________________________

Case usual place of residency: Country: ______________________________

Section 2: Clinical Status

Date of first laboratory confirmation test: [D][D]/[M][M]/[Y][Y][Y][Y]

Any symptoms* or signs at time of specimen collection that resulted in first laboratory confirmation?
☐ No (i.e., asymptomatic)        ☐ Yes        ☐ Unknown

If yes, date of onset of symptoms: [D][D]/[M][M]/[Y][Y][Y][Y]

Underlying conditions and comorbidity:

Any underlying conditions? ☐ No ☐ Yes ☐ Unknown

If yes, please check all that apply:
☐ Pregnancy (trimester: ____________)
☐ Cardiovascular disease, including hypertension
☐ Diabetes
☐ Liver disease
☐ Chronic neurological or neuromuscular disease
☐ Other(s), please specify:

☐ Post-partum (< 6 weeks)
☐ Immunodeficiency, including HIV
☐ Renal disease
☐ Chronic lung disease
☐ Malignancy
Health Status at time of reporting:

Admission to hospital: □ No □ Yes □ Unknown
First date of admission to hospital: [D] [D]/[M]/[Y] [Y] [Y] [Y]

If yes
Did the case receive care in an intensive care unit (ICU)? □ No □ Yes □ Unknown
Did the case receive ventilation? □ No □ Yes □ Unknown
Did the case receive extracorporeal membrane oxygenation? □ No □ Yes □ Unknown

Is case in isolation with Infection Control Practice in place □ No □ Yes □ Unknown
Date of isolation: [D]/[M]/[Y] [Y] [Y] [Y]

Section 3: Exposure risk in the 14 days prior to symptom onset (prior to testing if asymptomatic)

Is case a Health Care Worker (any job in a health care setting): □ No □ Yes □ Unknown

If yes, Country: ____________________ City: ____________________ Name of Facility: _______________________________________

Has the case travelled in the 14 days prior to symptom onset? □ No □ Yes □ Unknown
If yes, please specify the places the patient travelled to and date of departure from the places:

<table>
<thead>
<tr>
<th>Country</th>
<th>City</th>
<th>Date of Departure from the place</th>
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Has case visited any health care facility in the 14 days prior to symptom onset? □ No □ Yes □ Unknown

Has case had contact with a 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:
If yes, please explain contact setting: _____________________________________________________________________________________
____________________________________________________________________________________________________________________________

<table>
<thead>
<tr>
<th>Contact ID</th>
<th>First Date of Contact</th>
<th>Last Date of Contact</th>
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Most likely country of exposure: ______________________________________________________________
Section 4: Outcome: complete and re-sent the full form as soon as outcome of disease is known or after 30 days after initial report.

Date of re-submission of this report: [D][D]/[M]/[Y]/[Y]/[Y]/[Y]

If case was asymptomatic at time of specimen collection resulting in first laboratory confirmation, did the case develop any symptoms or signs at any time prior to discharge or death:

- No (i.e., case remains asymptomatic)
- Yes, asymptomatic case (as previously reported) developed symptoms and/or signs of illness

If yes, date of onset of symptoms/signs of illness: [D]/[D]/[M]/[M]/[Y]/[Y]/[Y]/[Y]

- Unknown

Clinical Course:
Admission to hospital (may have been previously reported): No  Yes  Unknown

If admitted to hospital:
First date of admission to hospital: [D]/[D]/[M]/[M]/[Y]/[Y]/[Y]/[Y]

- Did the case receive care in an intensive care unit (ICU)? No  Yes  Unknown
- Did the case receive ventilation? No  Yes  Unknown
- Did the case receive extracorporeal membrane oxygenation? No  Yes  Unknown

Health Outcome: Recovered/Healthy  Not recovered  Death  Unknown:  Other:

If other, please explain: ______________________________________________________________________________________

Date of Release from isolation/hospital or Date of Death: [D]/[D]/[M]/[M]/[Y]/[Y]/[Y]/[Y]

If released from hospital/isolation, date of last laboratory test: [D]/[D]/[M]/[M]/[Y]/[Y]/[Y]/[Y]

Results of last test: positive  negative  Unknown

Total number of contacts followed for this case: _________  Unknown

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