CASE REPORT FORM

Coronavirus Disease

COVID-19

EpiSurv No. EpiSurvNumber

Reporting Authority

Name of Public Health Officer responsible for case OfficerName

Notifier Identification

Reporting source* ReportSrc
◯ General Practitioner ◯ Hospital-based Practitioner ◯ Laboratory
◯ Self-notification ◯ Outbreak Investigation ◯ Other

Name of reporting source ReportName **Organisation** ReportOrganisation

Date reported* ReportDate dd/mm/yyyy **Contact phone** ReportPhone

Usual GP UsualGP **Practice** GPPracticeName **GP phone** GPPhone

GP/Practice address GPAddress
Number Street Suburb
Town/City Post Code ☐GeoCode

Case Identification

Name of case* Surname Surname Given Name(s) GivenName

NHI number* NHINumber **Email** Email

Current address* CaseAddress
Number Street Suburb
Town/City Post Code ☐GeoCode

Phone (home) PhoneHome **Phone (work)** PhoneWork **Phone (other)** PhoneOther

Case Demography

Location **TA*** TA **DHB*** DHB

Date of birth* DateOfBirth dd/mm/yyyy **OR** **Age** Age ◯ Days ◯ Months ◯ Years AgeUnits

Sex* Sex ◯ Male ◯ Female ◯ Indeterminate ◯ Unknown

Occupation* Occupation

Occupation location PlaceOfWork1Type ◯ Place of Work ◯ School ◯ Pre-school

Name PlaceOfWork1

Address PlaceOfWork1Address
Number Street Suburb
Town/City Post Code ☐GeoCode

Alternative location PlaceOfWork2Type ◯ Place of Work ◯ School ◯ Pre-school

Name

Address PlaceOfWork2Address
Number Street Suburb
Town/City Post Code ☐GeoCode

Ethnic group case belongs to* (tick all that apply)

☐NZ European EthNZEuropean ☐Maori EthMaori ☐Samoan EthSamoan ☐Cook Island Maori EthCookIslandMaori

☐Niuean EthNiuean ☐Chinese EthChinese ☐Indian EthIndian ☐Tongan EthTongan

☐ Other (such as Dutch, Japanese) EthOther *(specify) EthSpecify1 EthSpecify2

Basis of Diagnosis

CLINICAL CRITERIA

Fits clinical description* FitClinDes ○ Yes ○ No ○ Unknown

At the time of diagnosis, was the case asymptomatic?* Asymptomatic ○ Yes ○ No ○ Unknown

If the case did not have symptoms when diagnosed, did they later develop any symptoms?* DevSympt ○ Yes ○ No ○ Unknown

If yes, onset date for when the case later developed symptoms* DevSymptDt dd/mm/yyyy

List all symptoms (tick all that apply)*

☐ History of fever/chills Fever	☐ Runny nose Coryza	☐ Headache Headache	☐ Muscular pain PainMusc
☐ General weakness Weakness	☐ Shortness of breath ShBreath	☐ Irritability/confusion IritConfus	☐ Chest pain PainChest
☐ Cough Cough	☐ Diarrhoea Diarrhoea	☐ Loss of sense of smell Anosmia	☐ Abdominal pain PainAbdom
☐ Sore throat SoreThroat	☐ Nausea/vomiting NausVom	☐ Altered taste AlteredTaste	☐ Joint pain PainJoint

☐ Other symptoms, specify* OthSymptoms OthSymSpec ______

Clinical signs (tick all that apply)*

☐ Abnormal lung x-ray findings LungXray ☐ Other signs, specify* OthSign OthSignSpec ______

LABORATORY CRITERIA

Laboratory confirmation of disease* LabConf ○ Yes ○ No ○ Not Done ○ Awaiting Results

If yes, date of laboratory confirmation* LabConfDt dd/mm/yyyy

If yes, specify laboratory confirmation method (tick all that apply)*

Detection of SARS-CoV-2 from clinical specimen by NAAT (PCR) NAAT ○ Yes ○ No ○ Not Done ○ Awaiting Results

If yes, Ct value or strength of PCR (eg weak or strong) CtValue ______ Date CtDate1 dd/mm/yyyy

Second Ct value or strength of PCR CtValue2 ______ Date CtDate2 dd/mm/yyyy

Third Ct value or strength of PCR CtValue3 ______ Date CtDate3 dd/mm/yyyy

Rapid antigen test RapidAg ○ Yes ○ No ○ Not Done ○ Awaiting Results Date RapidAgDt dd/mm/yyyy

Second rapid antigen test RapidAg2 ○ Yes ○ No ○ Not Done ○ Awaiting results Date RapidAg2Dt dd/mm/yyyy

Other positive test (specify)* OthPosTest ______

EPIDEMIOLOGICAL CRITERIA

Did the case have close contact with a confirmed case?* EpiCont ○ Yes ○ No ○ Unknown

If contact was in New Zealand, EpiSurv number of confirmed case* EpiContID ______

CLASSIFICATION* Status ◉ Under investigation ○ Suspect ○ Probable ○ Confirmed ○ Not a case

Clinical Course and Outcome

Date of onset* OnsetDt dd/mm/yyyy ☐ Approximate OnsetDtApprox ☐ Unknown OnsetDtUnknown

Hospitalised* Hosp ○ Yes ○ No ○ Unknown

Date hospitalised* HospDt dd/mm/yyyy ☐ Unknown HospDtUnknown

Hospital* HospName ______

Died* Died ○ Yes ○ No ○ Unknown

Date died* DiedDt dd/mm/yyyy ☐ Unknown DiedDtUnknown

Was this disease the primary cause of death?* DiedPrimary ○ Yes ○ No ○ Unknown

If no, specify the primary cause of death* DiedOther ______

Additional Outcome Details

This section is to be completed as soon as outcome is known or 30 days after notification

Was the case in ICU?* ICU ◯ Yes ◯ No ◯ Unknown

Ventilation required* VentReqd ◯ Yes ◯ No ◯ Unknown

Extracorporeal membrane oxygenation required (ECMO)* ECMO ◯ Yes ◯ No ◯ Unknown

If case was hospitalised, date discharged from hospital* DischDt dd/mm/yyyy

Was severity of COVID-19 illness the primary reason for hospitalisation?*Severe ◯ Yes ◯ No ◯ Unknown

Outbreak Details

Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?*

☐ Yes Outbrk **If yes, specify Outbreak No.*** OutbrkNo

Name of sub-cluster that the case is part of (as agreed with the Ministry of Health)* SubCluster

Risk Factors

Is the case a health care worker (any job in a health care setting)?* HealthWorker ◯ Yes ◯ No ◯ Unknown

Does the case live in any of the facilities listed below?

Residential care (e.g. aged, disability or other institutional community care) ResidCare ◯ Yes ◯ No ◯ Unknown

Hostel-style accommodation (e.g. transitional facility, student hall, backpackers) Hostel ◯ Yes ◯ No ◯ Unknown

Corrections facility Prison ◯ Yes ◯ No ◯ Unknown

Was the case overseas in the 10 days prior to onset (or prior to reporting if asymptomatic)?* Overseas ◯ Yes ◯ No ◯ Unknown

If yes, date arrived in New Zealand* DtArrived dd/mm/yyyy

Specify countries and cities visited (from most to least recent) for cases with recent travel and historic cases*

Sequence	Country	City/Region	Date Entered		Date Departed	
Last:*			LastDtEntered	dd/mm/yyyy	eparted	dd/mm/yyyy
Second Last:*			SecDtEntered	dd/mm/yyyy	parted	dd/mm/yyyy
Third Last:*			ThirdDtEntered	dd/mm/yyyy	Departed	dd/mm/yyyy

Underlying conditions (tick all that apply)*

☐ Pregnancy Pregnancy If yes, trimester Trimester

☐ Post-partum (< 6 weeks) PostPartum

☐ Cardiovascular disease, including hypertension CVD

☐ Immunodeficiency, including HIV Immunodef

☐ Diabetes Diabetes

☐ Renal failure RenalFailure

☐ Liver disease LiverDis

☐ Chronic lung disease ChronLung

☐ Chronic neurological or neuromuscular disease Neurological

☐ Malignancy Malignancy

☐ Other underlying condition, specify OthUndCond OthCondSpec

Other risk factors for disease* RiskSpec

Protective factors

Prior to onset (or prior to reporting if asymptomatic), had the case been immunised with appropriate vaccine?* Immunised ○ Yes ○ No ○ NA ○ Unknown

If yes specify vaccine details*

How many doses did the case receive prior to onset? NumDoses

	Date given		Date unknown	Name of vaccine	Batch number
First dose	DtFirstDose	dd/mm/yyyy	Dose1DtUnk	Dose1Vacc	Dose1Batch
Second dose	DtSecondDose	dd/mm/yyyy	Dose2DtUnk	Dose2Vacc	Dose2Batch
Booster (3rd) dose	DtThirdDose	dd/mm/yyyy	Dose3DtUnk	Dose3Vacc	Dose3Batch

If yes, how was vaccination status confirmed* ImmBasis ○ Patient/Caregiver recall ○ Documented ○ NA ○ Unknown

Where was the case vaccinated?* VaccCountry ○ New Zealand ○ Other country (specify) VaccCountrySpec

Did the case receive antivirals? Antivirals ○ Yes ○ No ○ Unknown

If yes, specify antivirals received AntiviralSpec

Comments*

Comments