COVID-19 CASE FORM

March 2020

Patient Details

Surname		First name		
Country of Residence		Gender	Male	Female
Date of Birth		Age (years)		
Residential address		Country of Birth		
Cell phone no.		Email address		
Other contact information		Occupation		
GP name		GP phone no.		
GP email		**Accession no.**		

Clinical Details

Patient type	GP		ED	Hospital out-patient	Hospital in-patient		Other	
Is patient symptomatic?	Yes	No	Unknown	Date of onset of symptoms		Date of diagnosis		
Patient symptoms	Yes	No	Unknown	Patient symptoms	Yes	No	Unknown	Other symptoms
History of fever/chills				*Abdominal pain*				
General weakness				*Joint pain*				
Cough				*Muscle pain*				
Sore throat				*Diarrhoea*				
Runny nose				*Nausea/Vomiting*				
Shortness of breath				*Headache*				
Chest pain				*Irritability/Confusion*				
Patient signs	Yes			No	Unknown			
Temperature ≥38°C								
Abnormal lung X-ray findings								
If hospital in-patient								
Hospital number				Hospital name				
Admitted to ICU	Yes	No	Unknown					

Exposure Details

International travel in 14 days prior to symptom onset?				Yes	No	Unknown	
Airport of departure				Airport of arrival		Airline	
Did patient visit live animal markets?	Yes	No	Unknown	If yes, name and location			
Did patient eat/drink from market?	Yes	No	Unknown	If yes, specify details			
Attend mass gathering in 14 days prior to symptom onset?	Yes	No	Unknown	If yes, date of attendance		If yes, place of attendance	
Close contact with COVID-19 case in 14 days prior to symptom onset?	Yes	No	Unknown	If yes, specify			
If yes, country and location of exposure				Did the patient receive care in a healthcare facility	Yes	No	Unknown
If yes, Healthcare Facility name							

Branch of Service : .....

Staff member(s) : .....

- **Radiographer** : .....
- **Receptionist** : .....
- **Other** : .....

Date of Service : .....

Follow up / Patient results : .....

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