Philippine Integrated Disease Surveillance and Response

Case Investigation Form
Coronavirus Disease (COVID-19)

Disease Reporting Unit/Hospital:	Name of Investigator:	Date of Interview:

1. Patient Profile

Last Name	First Name	Middle Name	Birthday (mm/dd/yyyy)	Age	Sex: ☐ Male ☐ Female
Occupation	Civil Status	Nationality		Passport No.	

2. Philippine Residence

2.1. Permanent Address

House No./Lot/Bldg.	Street/Barangay	Municipality/City	Province
Region	Home Phone No.	Cellphone No.	Email address

2.2. Current Address

House No./Lot/Bldg.	Street/Barangay	Municipality/City	Province
Region	Home Phone No.	Work Phone No.	Other Email address

3. Address Outside the Philippines (for Overseas Filipino Workers and Individuals with Residence Outside the Philippines)

Employer's Name:	Occupation	Place of Work:
House No./Bldg. Name	Street	City/Municipality	Province
Country:	Office Phone No.:	Cellphone No.:

4. Travel History

History of travel/visit/work in other countries with a known COVID-19 transmission 14 days before the onset of your signs and symptoms: ☐ Yes ☐ No	Port (Country) of exit:		
Airline/Sea vessel:	Flight/Vessel Number:	Date of Departure (mm/dd/yyyy)	Date of Arrival in Philippines:

5. Exposure History

History of **Exposure to Known COVID-19 Case** 14 days before the onset of signs and symptoms: ☐ Yes ☐ No ☐ Unknown	If yes: Date of Contact with Known COVID-19 Case (mm/dd/yyyy):
Have you been in a **place with a known COVID-19 transmission** 14 days before the onset of signs and symptoms: ☐ Yes ☐ No ☐ Unknown	If yes: Place: ☐ Work place ☐ Health facility ☐ Social gathering ☐ Religious gathering ☐ Others: specify type: _____
	Date when you have been in that place:
	Name of the place:

List the names of persons who were with you during this (these) occasion(s) and their contact numbers: *Use the back part of this sheet when needed*	**Name**	**Contact number**
	1.	
	2.	
	3.	

6. Clinical Information

Disposition at Time of Report ☐ Inpatient ☐ Outpatient ☐ Discharged ☐ Died ☐ Unknown	
Date of Onset of Illness (mm/dd/yyyy): _____/_____/_____	Date of Admission/Consultation (mm/dd/yyyy): _____/_____/_____
Fever _____ °C ☐ Cough ☐ Sore throat ☐ Colds ☐ Shortness/difficulty of breathing	
Other signs/symptoms, specify	Is there any history of other illness? ☐ Yes ☐ No If YES, specify:
Chest X-ray done? ☐ Yes ☐ No If yes, when? _____	Are you pregnant? ☐ Yes ☐ No LMP _____ Assessed as High Risk? ☐ Yes ☐ No
CXR Results: Pneumonia ☐ Yes ☐ No ☐ Pending	Other Radiologic Findings:

7. Specimen Information

Specimen Collected	if YES, Date Collected (mm/dd/yyyy)	Date sent to RITM (mm/dd/yyyy)	Date received in RITM *(to be filled up by RITM)*	Virus Isolation Result	PCR Result
☐ Serum	_____/_____/_____	____/_____/_____	____/_____/_____		
☐ Oropharyngeal / Nasopharyngeal swab	_____/_____/_____	____/_____/_____	____/_____/_____		
☐ Others	_____/_____/_____	____/_____/_____	____/_____/_____		

8. Classification

☐ Suspect Case	☐ Probable Case	☐ Confirmed Case

9. Outcome

Date of Discharge (mm/dd/yyyy): _____/_____/_____	Condition on Discharge: ☐ Improved ☐ Recovered ☐ Transferred ☐ Absconded ☐ Died

Name of Informant: (if patient not available)	Relationship:	Phone No.

Kindly use and fill-up this space if needed