

Michigan Interim 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI)/Case Report Form Cover Sheet

Please use the attached **Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form**. If you are a healthcare provider with a suspect COVID-19 PUI, contact your local health department (LHD). The LHD can assist in determining whether the individual meets the current CDC PUI criteria for testing (see below). If you are unable to reach an LHD contact, please call the Michigan Department of Health and Human Services (MDHHS) Communicable Disease (CD) Division at the numbers below.

For patients meeting the CDC PUI criteria for testing, the MDHHS CD Division will assign an nCoV ID number. An nCoV ID number **MUST** be assigned prior to submitting specimens to the MDHHS Bureau of Laboratories (BOL). The MDHHS CD Division can be contacted at: **(517) 335-8165** during business hours, or at: (517) 335-9030 after-hours and on holidays.

Evaluating and Reporting Persons Under Investigation (PUI): Local/State health departments, in consultation with clinicians, should determine whether a patient is a PUI for COVID-2019. The CDC clinical criteria for COVID-19 PUIs have been developed based on available information about this novel virus, as well as what is known about Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS). These criteria are subject to change as additional information becomes available.

For more information, please see: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>

Clinical features and epidemiologic risk		
Clinical Features	&	Epidemiologic Risk
Fever ¹ or signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	AND	Any person, including health care workers ² , who has had close contact ³ with a laboratory-confirmed ⁴ COVID-19 patient within 14 days of symptom onset
Fever ¹ and signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	AND	A history of travel from affected geographic areas ⁵ (see below) within 14 days of symptom onset
Fever ¹ with severe acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization ⁴ and without alternative explanatory diagnosis (e.g., influenza) ⁶	AND	No source of exposure has been identified

The criteria are intended to serve as guidance for evaluation. In consultation with public health departments, patients should be evaluated on a case-by-case basis to determine the need for testing. Testing may be considered for deceased persons who would otherwise meet the PUI criteria.

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Footnotes:

¹Fever may be subjective or confirmed.

²For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation.

³Close contact is defined as—*a*) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case—*or* —*b*) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on). If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met. See CDC's updated [Interim Infection Prevention and Control Recommendations for Patients with Confirmed COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings](#). Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to healthcare personnel exposed in healthcare settings as described in CDC's [Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with COVID-19](#).

⁴Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.

⁵Affected areas are defined as geographic regions where sustained community transmission has been identified. Relevant affected areas will be defined as a country with at least a CDC Level 2 Travel Health Notice. See all [COVID-19 Travel Health Notices](#).

⁶ Category includes single or clusters of patients with severe acute lower respiratory illness (e.g., pneumonia, ARDS) of unknown etiology in which COVID-19 is being considered.

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After approval, the completed PUI/Case Report form with intact cover sheet (with patient identifiers below) should be faxed to the MDHHS Communicable Disease Division at (517) 335-8263 or uploaded to the Michigan Disease Surveillance System (MDSS) if the patient has been entered into the MDSS.

Patient Information:

First name: _____ Last name: _____

nCoV ID#: MI-_____

(Note: An nCoV ID # must be obtained from MDHHS prior to specimens being submitted from the healthcare facility to the MDHHS BOL for COVID-19 testing)

MDSS ID number (MDHHS/LHD use): _____

Date of birth: _____/_____/_____ Age: _____ Sex: Female Male

Patient residence street address: _____ City: _____

County: _____ State: _____ Zip Code: _____

Patient phone number(s): _____/_____

Patient hospital ID (Medical Record) number: _____

Reporting healthcare facility: _____

Reporting healthcare facility contact name and title: _____

Healthcare facility contact phone number: _____

For additional information about 2019 Novel Coronavirus (COVID-19), please see:

<https://www.cdc.gov/coronavirus/2019-ncov/index.html>

<https://www.michigan.gov/coronavirus>

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ___/___/___

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....



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Reporting jurisdiction: _____ Case state/local ID: _____
Reporting health department: _____ CDC 2019-nCoV ID: _____
Contact ID ^a: _____ NNDSS loc. rec. ID/Case ID ^b: _____

a. Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case CA102034567 has contacts CA102034567 -01 and CA102034567 -02. ^bFor NNDSS reporters, use GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Last _____ First _____

Affiliation/Organization: _____ Telephone _____ Email _____

Basic information

What is the current status of this person? <input type="checkbox"/> Patient under investigation (PUI) <input type="checkbox"/> Laboratory-confirmed case Report date of PUI to CDC (MM/DD/YYYY): _____ Report date of case to CDC (MM/DD/YYYY): _____ County of residence: _____ State of residence: _____		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Not specified Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other		Date of first positive specimen collection (MM/DD/YYYY): ___/___/___ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A Did the patient develop pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No Did the patient have acute respiratory distress syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No Did the patient have another diagnosis/etiology for their illness? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No Did the patient have an abnormal chest X-ray? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No		Was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, admission date 1 ___/___/___ (MM/DD/YYYY) If yes, discharge date 1 ___/___/___ (MM/DD/YYYY) Was the patient admitted to an intensive care unit (ICU)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the patient receive mechanical ventilation (MV)/intubation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, total days with MV (days) _____ Did the patient receive ECMO? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the patient die as a result of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of death (MM/DD/YYYY): ___/___/___ <input type="checkbox"/> Unknown date of death	
Race (check all that apply): <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____		Date of birth (MM/DD/YYYY): ___/___/___ Age: _____ Age units(yr/mo/day): _____					
Symptoms present during course of illness: <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Unknown		If symptomatic, onset date (MM/DD/YYYY): ___/___/___ <input type="checkbox"/> Unknown		If symptomatic, date of symptom resolution (MM/DD/YYYY): ___/___/___ <input type="checkbox"/> Still symptomatic <input type="checkbox"/> Unknown symptom status <input type="checkbox"/> Symptoms resolved, unknown date			
Is the patient a health care worker in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Does the patient have a history of being in a healthcare facility (as a patient, worker or visitor) in China? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply): <input type="checkbox"/> Travel to Wuhan <input type="checkbox"/> Community contact with another lab-confirmed COVID-19 case-patient <input type="checkbox"/> Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology <input type="checkbox"/> Travel to Hubei <input type="checkbox"/> Any healthcare contact with another lab-confirmed COVID-19 case-patient <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Travel to mainland China <input type="checkbox"/> Patient <input type="checkbox"/> Visitor <input type="checkbox"/> HCW <input type="checkbox"/> Unknown <input type="checkbox"/> Travel to other non-US country specify: _____ <input type="checkbox"/> Household contact with another lab-confirmed COVID-19 case-patient <input type="checkbox"/> Animal exposure							
If the patient had contact with another COVID-19 case, was this person a U.S. case? <input type="checkbox"/> Yes, nCoV ID of source case: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A							
Under what process was the PUI or case first identified? (check all that apply): <input type="checkbox"/> Clinical evaluation leading to PUI determination <input type="checkbox"/> Contact tracing of case patient <input type="checkbox"/> Routine surveillance <input type="checkbox"/> EpiX notification of travelers; if checked, DGMQID _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____							

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).



CDC 2019-nCoV ID:

Form Approved: OMB: 0920-1011 Exp. 4/23/2020

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Symptoms, clinical course, past medical history and social history

Collected from (check all that apply): Patient interview Medical record review

During this illness, did the patient experience any of the following symptoms?	Symptom Present?		
Fever >100.4F (38C) ^c	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Subjective fever (felt feverish)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Chills	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Muscle aches (myalgia)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Runny nose (rhinorrhea)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Sore throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Cough (new onset or worsening of chronic cough)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Shortness of breath (dyspnea)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Nausea or vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Diarrhea (≥3 loose/looser than normal stools/24hr period)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Other, specify: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk

Pre-existing medical conditions? Yes No Unknown

Chronic Lung Disease (asthma/emphysema/COPD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Diabetes Mellitus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Cardiovascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Chronic Renal disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Chronic Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Immunocompromised Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Neurologic/neurodevelopmental	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(If YES, specify) _____
Other chronic diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(If YES, specify) _____
If female, currently pregnant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Current smoker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Former smoker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	

Respiratory Diagnostic Testing

Test	Pos	Neg	Pend.	Not done
Influenza rapid Ag <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza PCR <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. metapneumovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parainfluenza (1-4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adenovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rhinovirus/enterovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronavirus (OC43, 229E, HKU1, NL63)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. pneumoniae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. pneumoniae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specimens for COVID-19 Testing

Specimen Type	Specimen ID	Date Collected	Sent to CDC	State Lab Tested
NP Swab			<input type="checkbox"/>	<input type="checkbox"/>
OP Swab			<input type="checkbox"/>	<input type="checkbox"/>
Sputum			<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify: _____			<input type="checkbox"/>	<input type="checkbox"/>

Additional State/local Specimen IDs: _____

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