CASE REPORT FORM

Coronavirus Disease

EpiSurv No.

Reporting Authority

Name of Public Health Officer responsible for case

Notifier Identification

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

Name of reporting source **Organisation**

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

Usual GP **Practice** **GP phone**

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

Case Identification

Name of case* Surname Given Name(s)

NHI number* **Email**

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

Phone (home) **Phone (work)** **Phone (other)**

Case Demography

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

Date of birth* dd/mm/yyyy **OR** **Age** ○ Days ○ Months ○ Years

Sex* ○ Male ○ Female ○ Indeterminate ○ Unknown

Occupation*

Occupation location ○ Place of Work ○ School ○ Pre-school

Name

Address Number Street Suburb Town/City Post Code ☐ GeoCode

Alternative location ○ Place of Work ○ School ○ Pre-school

Name

Address Number Street Suburb Town/City Post Code ☐ GeoCode

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

☐ NZ European ☐ Maori ☐ Samoan ☐ Cook Island Maori

☐ Niuean ☐ Chinese ☐ Indian ☐ Tongan

☐ Other (such as Dutch, Japanese, Tokelauan) *(specify)

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Basis of Diagnosis

CLINICAL CRITERIA

Fits clinical description* ○ Yes ○ No ○ Unknown

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

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

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

List all symptoms (tick all that apply)*

- ☐ History of fever/chills
- ☐ Runny nose
- ☐ Headache
- ☐ Muscular pain
- ☐ General weakness
- ☐ Shortness of breath
- ☐ Irritability/confusion
- ☐ Chest pain
- ☐ Cough
- ☐ Diarrhoea
- ☐ Loss of sense of smell
- ☐ Abdominal pain
- ☐ Sore throat
- ☐ Nausea/vomiting
- ☐ Altered taste
- ☐ Joint pain
- ☐ Other symptoms, specify*

Clinical signs (tick all that apply)

- ☐ Abnormal lung x-ray findings
- ☐ Other signs, specify

LABORATORY CRITERIA

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

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

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

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

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

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

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

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

Second rapid antigen test ○ Yes ○ No ○ Not Done ○ Awaiting Results Date dd/mm/yyyy

Other positive test (specify)

EPIDEMIOLOGICAL CRITERIA

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

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

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

Clinical Course and Outcome

Date of onset* dd/mm/yyyy ☐ Approximate ☐ Unknown

Hospitalised* ○ Yes ○ No ○ Unknown

Date hospitalised* dd/mm/yyyy ☐ Unknown

Hospital*

Died* ○ Yes ○ No ○ Unknown

Date died* dd/mm/yyyy ☐ Unknown

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

If no, specify the primary cause of death*

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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?* ◯ Yes ◯ No ◯ Unknown

Ventilation required* ◯ Yes ◯ No ◯ Unknown

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

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

Was severity of COVID-19 illness the primary reason for hospitalisation?* ◯ 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 **If yes, specify Outbreak No.***

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

Risk Factors

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

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

Corrections facility ◯ Yes ◯ No ◯ Unknown

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

If yes, date arrived in New Zealand 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:*			dd/mm/yyyy	dd/mm/yyyy
Second Last:*			dd/mm/yyyy	dd/mm/yyyy
Third Last:*			dd/mm/yyyy	dd/mm/yyyy

Underlying conditions (tick all that apply)*

☐ Pregnancy If yes, trimester

☐ Cardiovascular disease, including hypertension

☐ Diabetes

☐ Liver disease

☐ Chronic neurological or neuromuscular disease

☐ Other underlying condition, specify*

☐ Post-partum (< 6 weeks)

☐ Immunodeficiency, including HIV

☐ Renal failure

☐ Chronic lung disease

☐ Malignancy

Other risk factors for disease

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Protective factors

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

If yes, specify vaccine details

How many doses did the case receive prior to onset?

	Date given	Date unknown	Name of vaccine	Batch number
First dose	dd/mm/yyyy	☐		
Second dose	dd/mm/yyyy	☐		
Booster (3rd) dose	dd/mm/yyyy	☐		

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

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

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

If yes, specify antivirals received

Comments*