Philippine Integrated

Disease Surveillance

and Response



**Case Investigation Form**

**Coronavirus Disease (COVID-19)** Version 7

**General Instructions:**

1. The Case Investigation Form is meant to be administered as an Interview by a health care worker or any personnel of the Disease Reporting Unit. **This is not a Self-Administered Questionnaire**.
2. Please be advised that Disease Reporting Units are only allowed to obtain **1 copy of accomplished CIF** from a patient.
3. Please fill out all blanks and put a check mark on the appropriate box. Never leave an item blank, just write N/A or not applicable. **Items with \* are required fields.**
4. All dates must be in **MM/DD/YYYY format.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Disease Reporting Unit\*** | | | | | | **DRU Region and Province** | | | | | **PhilHealth No.\*** | | | | | |
| UP HEALTH SERVICE | | | | | | NATIONAL CAPITAL REGION | | | | |  | | | | | |
| **Name of Interviewer** | | | | | | **Contact Number of Interviewer** | | | | | **Date of Interview (MM/DD/YYYY)\*** | | | | | |
| DR. ALIZA M. PANGAIBAT | | | | | | 89818500 LOCAL 111 | | | | |  | | | | | |
| **Name of Informant**  **(If patient unavailable)** | | | | | | **Relationship** | | | | | **Contact Number of Informant** | | | | | |
|  | | | | | |  | | | | |  | | | | | |
| **Type of Client** | | COVID-19 Case (Suspect, Probable, or Confirmed)  Close Contact  For RT-PCR Testing (Not a Case of Close Contact)  Others, please specify: \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| **1. Testing Category/Subgroup (Check all that apply) *Refer to Appendix 1*** | | | | | | | | | | | | | | | | |
| **A** | **B** | | **C** | | **D** | | **E** | | **F** | **G** | | | | **H** | **I** | **J** |
| **Part 1. Patient Information** | | | | | | | | | | | | | | | | |
| **2. Patient Profile** | | | | | | | | | | | | | | | | |
| Last Name\* | | | | | | First Name (and Suffix)\* | | | | | | | Middle Name\* | | | |
| Birthday (MM/DD/YYYY)\* | | | | | | Age\* | | | | | | | Sex\* Male Female | | | |
| Civil Status | | | | | | Nationality | | | | | | | Occupation | | | |
| Specific Occupation | | | | | | Status of employment in UP | | | | | | | Reporting Status | | | |
| Faculty  REPS  Staff  Health worker  Custodial worker (Agency)  Security Guard  Construction worker  Ambulant vendor | | | | | | UP Permanent  UP Contractual  Non-UP Contractual  Agency Hire  Job Order/ Project based/ Contract of Service | | | | | | | Fully work from home  Partial work from home with a regular schedule (physically reporting at least once a week)  Partial work from home with irregular schedule (physically reporting on a non-regular schedule, WFH rest of the time)  Others, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **3. Current Address in the Philippines and Contact Information\* (Give address of institution if you live in closed settings, see Part 2 #9)** | | | | | | | | | | | | | | | | |
| House No./Lot/Bldg. | | | | Street/Purok/Sitio | | | | | Barangay | | | Municipality/City | | | | |
|  | | | |  | | | | |  | | |  | | | | |
| Province | | | | Home Phone No. (& Area Code) | | | | | Cellphone No. | | | Email Address | | | | |
|  | | | |  | | | | |  | | |  | | | | |
| **4. Current Workplace Address and Contact Information (Indicate Department, Office and Unit)** | | | | | | | | | | | | | | | | |
| Lot/Bldg. | | | | Street | | | | | Barangay | | | Municipality/City | | | | |
|  | | | |  | | | | |  | | |  | | | | |
| Province | | | | Name of Workplace | | | | | Phone No./  Cellphone No. | | | Email Address | | | | |
|  | | | |  | | | | |  | | |  | | | | |
| **5. Consultation and Admission Information** | | | | | | | | | | | | | | | | |
| Did you have previous COVID-19 related consultation? | | | | | | | | Yes, Date of First Consult(MM/DD/YYYY)\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No | | | | | | | | |
| Name of facility where first consult was done | | | | | | | |  | | | | | | | | |
| Was the case admitted in a health facility? | | | | | | | | Yes, Date of Admission (MM/DD/YYYY)\* *Indicate earliest date if*  *admitted in multiple health facilities \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  No | | | | | | | | |
| Name of Facility where patient was first admitted | | | | | | | |  | | | | | | | | |
| Region and Province of Facility | | | | | | | |  | | | | | | | | |
| **6. Disposition at Time of Report\* (Provide name of hospital/isolation/quarantine facility)** | | | | | | | | | | | | | | | | |
| Admitted in hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date and Time admitted in hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Admitted in isolation/quarantine facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date and Time isolated/quarantined in facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_ In home isolation/quarantine Date and Time isolated/quarantined at home \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharged to home If Discharged: Date of Discharge (MM/DD/YYYY)\* \_\_\_\_\_\_\_\_\_\_\_\_\_ Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |
| **7. Health Status at Consult\*** | | | | | | | | | | | | | | | | |
| Asymptomatic  Mild  Moderate  Severe  Critical | | | | | | | | | | | | | | | | |
| **8. Case Classification\* (*Refer to Appendix 2)*** | | | | | | | | | | | | | | | | |
| Suspect  Probable  Confirmed  Non-COVID-19 Case | | | | | | | | | | | | | | | | |
| **PART 2: Case Investigation Details** | | | | | | | | | | | | | | | | |
| **9. Special Population** | | | | | | | | | | | | | | | | |
| Health Care Worker\* | | | | Yes, Name & location of health facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No | | | | | | | | | | | | |
| Returning Overseas Filipino\* | | | | Yes, Country of origin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No | | | | | | | | | | | | |
| Foreign National Traveler\* | | | | Yes, Country of origin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No | | | | | | | | | | | | |
| Locally Stranded  Individual/APOR/Traveler\* | | | | Yes, City, Mun, & Prov of origin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No | | | | | | | | | | | | |
| Lives in Closed Settings\* | | | | Yes, specify Type of Institution (e.g. prisons, residential facilities, retirement No communities, care homes, camps etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  and specify Name of Institution \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- |
| **10. Permanent Address and Contact Information (If different from current address)** | | | | | | |
| House No./Lot/Bldg. | | Street /Purok/Sitio | | Barangay | Municipality/City | |
|  | |  | |  |  | |
| Province | | Home Phone No. (& Area Code) | | Cellphone No. | Email Address | |
|  | |  | |  |  | |
| **11. Address Outside the Philippines and Contact Information (for Overseas Filipino Workers and Individuals with Residence outside PH)** | | | | | | |
| House No./Lot/Bldg. | | Street | | Municipality/City | Province | |
|  | |  | |  |  | |
| Country | | Place of Work | | Employer’s Name | Employer’s/Office Contact No. | |
|  | |  | |  |  | |
| **12. Clinical Information** | | | | | | |
| Date of Onset of Illness (MM/DD/YYYY)\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Comorbidities (Check all that apply if present) | | |
| Signs and Symptoms (Check all that apply if present) | | | |
| Asymptomatic  Dyspnea    Fever \_\_\_\_\_ °C  Anorexia  Cough  Nausea  General weakness  Vomiting  Fatigue  Diarrhea    Headache  Altered Mental Status    Myalgia  Anosmia (loss of smell)    Sore throat  Ageusia (loss of taste)    Coryza  Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | None  Gastrointestinal    Hypertension  Genito-urinary    Diabetes  Neurological Disease    Heart Disease  Cancer    Lung Disease  Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Are you pregnant? | | Yes, LMP \_\_\_\_\_\_\_\_\_  No |
| High-risk pregnancy? | | Yes  No |
| Were you diagnosed to have Severe Acute Respiratory Illness? *(Refer to Appendix 2)*  Yes  No | | | | | | |
| Chest imaging findings suggestive of COVID-19 | | | | | | |
| Imaging Done (Check all that apply) | Results | | | | | |
| Chest radiography | Normal Hazy opacities, often rounded in morphology, with peripheral and lower lung distribution  Pending Other findings, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Chest CT | Normal Multiple bilateral ground glass opacities, often rounded in morphology, with peripheral and lower lung distribution  Pending Other findings, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Lung ultrasound | Normal Thickened pleural lines, B lines (multifocal, discrete, or confluent), consolidative patterns with or without air bronchograms.    Pending Other findings, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| None | | | | | | |
| **13. Laboratory Information** | | | | | | |
| Test Done\* (Check all that apply) | Date Collected\* | | Laboratory | Results\* | | Date Released |
| RT-PCR (OPS) |  | |  | Pending Positive  Negative Equivocal | |  |
| RT-PCR (NPS) |  | |  | Pending Positive  Negative Equivocal | |  |
| RT-PCR (OPS and NPS) |  | |  | Pending Positive  Negative Equivocal | |  |
| RT-PCR (specimen type \_\_\_\_\_\_\_\_\_\_) |  | |  | Pending Positive  Negative Equivocal | |  |
| Antigen Test |  | |  | Pending Positive  Negative Equivocal | |  |
| Antibody Test |  | |  | IgM (+) IgG (-) IgG (+) IgM (-)  IgM (+) IgG (+) IgM (-) IgG (-) | |  |
| Others  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | |  | Specify Result: | |  |
| Have you ever tested positive using RT-PCR before?  Yes, Date of Specimen Collection (MM/DD/YYYY)\* \_\_\_\_\_\_\_\_\_\_\_  No  If Yes, Laboratory \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of previous RT-PCR swabs done \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **14. Outcome/Condition at Time of Report\*** | | | | | | |
| Active (Currently admitted or in isolation/quarantine) Recovered, Date of Recovery (MM/DD/YYYY)\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Died, Date of Death (MM/DD/YYYY)\* \_\_\_\_\_\_\_\_\_\_  Cause of Death\* Immediate Cause \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Antecedent Cause \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Underlying Cause \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Part 3: Contact Tracing** | | | | | | | |
| **15. Exposure History** | | | | | | | |
| History of exposure to known probable and/or confirmed COVID-19 case 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection?\* | | | | Yes, Date of LAST Contact (MM/DD/YYYY)\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No  Unknown | | | |
| Have you been in a place with a known COVID-19 community transmission 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection?\* | | | | Yes  No  Unknown exposure | | | |
| If Yes, specify place (Check all that apply, provide details such as name of establishment, transport service, venue, location etc. and date of visit in MM/DD/YYYY) | | | | | | | |
| Place Visited | Details | | Date of Visit | Place Visited | Details | | Date of Visit |
| Health Facility |  | |  | Transportation |  | |  |
| Closed Settings (e.g. Jail) |  | |  | Workplace |  | |  |
| Market |  | |  | Local Travel |  | |  |
| Home |  | |  | Social Gathering |  | |  |
| International  Travel |  | |  | Others |  | |  |
| School |  | |  |  |  | |  |
| **16. Travel History** | | | | | | | |
| History of travel/visit/work in other countries with a known COVID-19 transmission 14 days before the onset of signs and symptoms | | | | Yes, Country of exit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No | | | |
| Airline/Sea vessel | | Flight/Vessel Number | | Date of Departure  (MM/DD/YYYY) | | Date of Arrival in PH  (MM/DD/YYYY) | |
|  | |  | |  | |  | |
| History of travel/visit/work in other local place with a known COVID 19 transmission 14 days before the onset of signs and symptoms | | | | Yes, Place of origin\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No | | | |
| Airline/Sea vessel/Bus line/Train | | Flight/Vessel Number/ Bus No. | | Date of Departure  (MM/DD/YYYY) | | Date of Arrival in the Current City/Mun (MM/DD/YYYY) | |
|  | |  | |  | |  | |
| List the names of persons who were with you two days prior to onset of illness until this date and their contact numbers.  \*If asymptomatic, list the names of persons who were with you on the day you submitted specimen for testing until this date and their contact numbers. (*Use additional space below if needed).* | | | | Name | | Contact No. | |
|  | |  | |
|  | |  | |
|  | |  | |
|  | |  | |

**For Additional Close Contact (Include ALL Household Contacts)**

|  |  |  |
| --- | --- | --- |
| **Name** | **Contact Number** | **Exposure Setting (ex. Household, Work)** |
| **1.** |  |  |
| **2.** |  |  |
| **3.** |  |  |
| **4.** |  |  |
| **5.** |  |  |
| **6.** |  |  |
| **7.** |  |  |
| **8.** |  |  |
| **9.** |  |  |
| **10.** |  |  |