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 [x]  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** | [x]  **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.**  |  |  |