The First Few X (FFX): Cases and contact investigation protocol for 2019-nCoV

Form A2: Case follow-up reporting form – for confirmed cases (Day 14-21)

COMMENT: Information in this form may already have been completed in the Case Minimum Data Reporting Form (Form A1). It is therefore not necessary to repeat any data in these sections that has already been completed

Unique Case ID / Cluster Number (if applicable):

1. Data Collector Information	
Name of data collector	
Data collector Institution	
Data collector telephone number	
Email	
Form completion date (dd/mm/yyyy)	___/___/___

2. Interview respondent information (if different from initial interview)	
First name	
Surname	
Sex	□ Male □ Female □ Not known
Date of Birth (dd/mm/yyyy)	___/___/___
Relationship to patient	
Respondent address	
Telephone (mobile) number	

3. Outcome/status	
Status	□ Recovered, if yes specify date symptoms resolved ___/___/___ □ Still ill □ Dead, if yes specify date of death ___/___/___ □ Unknown/ Lost to follow-up
Hospitalization ever required?	□ Yes □ No □ Not Unknown
(NB. If the information below is not currently available, please leave blank and send through an update as soon as results are available)	
If dead, contribution of 2019-nCoV to death:	□ Underlying/primary □ Contributing/secondary □ No contribution to death □ Unknown
If dead, was a port-mortem performed?	□ Yes □ No □ Unknown
If dead, cause of death on Death certificate (specify)	
If dead, results of post-mortem's report where available:	

4a. Patient symptoms during the entirety of illness	
Maximum Temperature (specify)	˚C , □ NA
4b. Respiratory symptoms	
Sore throat	□ Yes □ No □ Unknown If Yes, date (dd/mm/yyyy) ___/___/___
Cough	□ Yes □ No □ Unknown If Yes, date (dd/mm/yyyy) ___/___/___
Runny nose	□ Yes □ No □ Unknown
Shortness of breath	□ Yes □ No □ Unknown If Yes, date (dd/mm/yyyy) ___/___/___
4c. Other symptoms	
Chills	□ Yes □ No □ Unknown
Vomiting	□ Yes □ No □ Unknown
Nausea	□ Yes □ No □ Unknown
Diarrhoea	□ Yes □ No □ Unknown
Headache	□ Yes □ No □ Unknown
Rash	□ Yes □ No □ Unknown
Conjunctivitis	□ Yes □ No □ Unknown
Muscle aches	□ Yes □ No □ Unknown
Joint ache	□ Yes □ No □ Unknown
Nausea	□ Yes □ No □ Unknown
Loss of appetite	□ Yes □ No □ Unknown
Nose bleed	□ Yes □ No □ Unknown
Fatigue	□ Yes □ No □ Unknown
Seizures	□ Yes □ No □ Unknown
Altered consciousness	□ Yes □ No □ Unknown
Other neurological signs	□ Yes □ No □ Unknown If Yes, specify
Other symptoms	□ Yes □ No □ Unknown If yes, specify:

5. Patient symptoms: Complications	
Hospitalization	□ Yes □ No □ Unknown
Date of first hospitalization	___/___/___ □ Unknown
ICU (Intensive Care Unit) Admission	□ Yes □ No □ Unknown
ICU admission	___/___/___ □ Unknown
Date of discharge from ICU	___/___/___ □ Unknown □ NA
Mechanical ventilation	□ Yes □ No □ Unknown
Dates of mechanical ventilation (dd/mm/yyyy)	Start___/___/___ Stop___/___/___ □ Unknown □ NA

Length of ventilation (days)	
Acute Respiratory Distress Syndrome (ADRS)	□ Yes □ No □ Unknown If yes, date started (dd/mm/yyyy)___/___/___
Acute renal failure	□ Yes □ No □ Unknown If yes, date started (dd/mm/yyyy)___/___/___
Cardiac failure	□ Yes □ No □ Unknown If yes, date started (dd/mm/yyyy)___/___/___
Consumptive coagulopathy	□ Yes □ No □ Unknown If yes, date started (dd/mm/yyyy)___/___/___
Pneumonia by chest X-ray	□ Yes □ No □ Unknown If yes, date started (dd/mm/yyyy)___/___/___
Hypotension requiring vasopressors	□ Yes □ No □ Unknown
Other complications s	□ Yes □ No □ Unknown If yes, specify:
Extracorporeal membrane oxygenation (EMO) required	□ Yes □ No □ Unknown

6. Patient pre-existing condition(s)	
Pregnancy	□ Yes □ No □ Unknown If yes, specify trimester: □ First □ Second □ Third □ NA

7. Secondary bacterial infection		
Complete a new line for each specimen collected and each type of test done:		
Date of sample	**Type of sample:**	**Positive results**
/ /	□ Sputum □ Endotracheal aspirate □ Pleural fluid □ CSF □ Blood □ Urine □ Faeces □ Other, please specify:	□ *Haemophilus influenza* □ MRSA □ *Staphylococcus aureus* □ *Streptococcus pneumoniae* □ E.coli □ Other organism, please specify:

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8a. Virology testing methods and results:							
Complete a new line for each specimen collected and each type of test done:							
Lab identification number	**Date Sample collected (dd/mm/yyyy)**	**Date Sample Received (dd/mm/yyyy)**	**Type of Sample**	**Type of test**	**Result**	**Result Date (dd/mm/yyyy)**	**Specimens shipped to other laboratory for confirmation**
	___/___/___	___/___/___	□ Nasal swab □ Throat swab □ Nasopharyngeal swab □ Others, specify:	□ PCR □ Whole genome sequencing □ Partial genome sequencing □ Other, specify	□ POSITIVE for 2019-nCoV □ NEGATIVE for 2019-nCoV □ POSITIVE for others pathogens Please specify which pathogens: ….	___/___/___	□ Yes If yes, specify Date ___/___/___ If yes, name of the laboratory: ____ □ No

8b. Serology testing methods and results:							
Complete a new line for each specimen collected and each type of test done:							
Lab identification number	**Date Sample collected (dd/mm/yyyy)**	**Date Sample Received (dd/mm/yyyy)**	**Type of Sample**	**Type of test**	**Result** (2019-nCoV antibody titres)	**Result date (dd/mm/yyyy)**	**Specimens shipped to other laboratory for confirmation**
	___/___/___	___/___/___	□ Serum □ Others, specify:	Specify type (ELISA / IFA IgM/ IgG, Neutralization assay, etc): ___	□ POSITIVE If positive, titre : ___ □ NEGATIVE □ INCONCLUSIVE	___/___/___	□ Yes If yes, specify Date ___/___/___ If yes, name of the laboratory: ____ □ No

9. Status of form completion	
Form completed	□ Yes □ No or partially If no or partially, reason : □ Missed □ Not attempted □ Not performed □ Refusal □ Other, specific: