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

Form A1: Case initial reporting form – for confirmed cases (Day 1)

COMMENT: Information in this form may already have been completed in the Case Minimum Data Reporting Form (Form A0). It is therefore not necessary to repeat any data in these sections that has already been completed.

But f Form A0 has never been completed, then all questions/ variables in Form A1 should be collected

Unique Case ID / Cluster Number (if applicable):

1. Current Status
□ Alive □ Dead □ Unknown/ Lost to follow-up
2. Further case classification
□ Primary □ Secondary □ Imported

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

4. Interview respondent information (if the persons providing the information is not the patient)	
First name	
Surname	
Sex	□ Male □ Female □ Not known
Date of Birth (dd/mm/yyyy)	___/___/___
Relationship to patient	
Respondent address	
Telephone (mobile) number	

5. Patient Identifier Information	
First name	
Surname	
Sex	□ Male □ Female □ Not known
Date of Birth (dd/mm/yyyy)	___/___/___
Telephone (mobile) number	
Age (years, months)	
Email	
Address	
National social number/ identifier (if applicable)	
Country of residence	

Nationality	
Ethnicity (optional)	
Responsible Health Centre	
Nursery/School/College if appropriate	

6. Health care center/ treating physicians details	
Name of treating physician	
Name of health care center	
Is this case part of an institutional outbreak?	□ Yes □ No □ Unknown If yes, specify:
Telephone number	
Fax	
Address	

7a. Patient symptoms from onset of symptoms	
Date of first symptom onset (dd/mm/yyyy)	___/___/___ □ Asymptomatic □ Unknown
Fever (≥38 °C) or history of fever	□ Yes □ No □ Unknown If yes, specify maximum temperature: °C
Date of first health facility visit (including traditional care) (dd/mm/yyyy)	___/___/___ □ NA □ Unknown
Total health facilities visited to date	□ NA □ Unknown Specify:
7b. 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): ___/___/___

7c. Other symptoms	
Chills	□ Yes □ No □ Unknown
Vomiting	□ Yes □ No □ Unknown
Nausea	□ Yes □ No □ Unknown
Diarrhea	□ 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
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:

8. Patient symptoms: Complications	
Hospitalization	□ Yes □ No □ Unknown
Date of first hospitalization	___/___/___ □ Unknown
ICU (Intensive Care Unit) Admission	□ Yes □ No □ Unknown
Date of ICU admission (dd/mm/yyyy)	___/___/___ □ Unknown
Date of discharge from ICU (dd/mm/yyyy)	___/___/___ □ 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 (ARDS)	□ 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) ___/___/___
Other complications	□ Yes □ No □ Unknown If yes, specify:
Extracorporeal membrane oxygenation (EMO) required	□ Yes □ No □ Unknown
Hypotension requiring vasopressors	□ Yes □ No □ Unknown
Date of discharge from hospital (if applicable) (dd/mm/yyyy)	___/___/___
Outcome	□ Alive □ Died □ NA □ Unknown
Outcome current as of date (dd/mm/yyyy)	___/___/___ □ Unknown □ NA

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

HIV/other immune deficiency	□ Yes □ No □ Unknown
Heart disease	□ Yes □ No □ Unknown
Asthma (requiring medication)	□ Yes □ No □ Unknown
Chronic lung disease (non-asthma)	□ Yes □ No □ Unknown
Chronic liver disease	□ Yes □ No □ Unknown
Chronic haematological disorder	□ Yes □ No □ Unknown
Chronic kidney disease	□ Yes □ No □ Unknown
Chronic neurological impairment/disease	□ Yes □ No □ Unknown
Organ or bone marrow recipient	□ Yes □ No □ Unknown
Other pre-existing condition(s)	□ Yes □ No □ Unknown If yes, specify:

10. Health care interactions	
Contact with emergency number/ hotline	□ Yes □ No □ Unknown
Date of emergency contact (dd/mm/yyyy)	___/___/___ □ Unknown
Visit to primary health care PHC (GP, etc) (repeat for as many visits as required)	□ Yes □ No □ Unknown
Date of first PHC contact (dd/mm/yyyy)	___/___/___ □ Unknown □ NA
Visited Emergency Department (A&E) (repeat for as many contacts as required)	□ Yes □ No □ Unknown
Date of first A&E contact (dd/mm/yyyy)	___/___/___ □ Unknown □ NA
Hospitalisation (repeat for as many admissions as required)	□ Yes □ No □ Unknown
Date of admission to hospital (dd/mm/yyyy)	___/___/___ □ Unknown □ NA
Name and place of hospital	

11. Human exposures in the 14 days before symptom onset	
Have you travelled within the last 14 days domestically?	□ Yes □ No □ Unknown If Yes, dates of travel (DD/MM/YYYY): ___/___/___ to ___/___/___ Regions: Cities visited:
Have you travelled within the last 14 days internationally?	□ Yes □ No □ Unknown If Yes, dates of travel (DD/MM/YYYY): ___/___/___ to ___/___/___ Countries visited: Cities visited:
In the past 14 days, have you had contact with a anyone with suspected or confirmed 2019-nCoV infection?	□ Yes □ No □ Unknown

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	If Yes, dates of last contact (DD/MM/YYYY): ___/___/___
Patient attended festival or mass gathering	□ Yes □ No □ Unknown If yes, specify:
Patient exposed to person with similar illness	□ Yes □ No □ Unknown
Location of exposure	□ Home □ Hospital □ Workplace □ Tour group □ School □ Unknown □ Other, specify:
Patient visited or was admitted to inpatient health facility	□ Yes □ No □ Unknown If yes, specify:
Patient visited outpatient treatment facility	□ Yes □ No □ Unknown If yes, specify:
Patient visited traditional healer	□ Yes □ No □ Unknown If yes, specify type:
Patient occupation (specify location/facility)	□ Health care worker □ Working with animals □ Health laboratory worker □ Student □ Other, specify: For each occupation, please specify location or facility:_______________________________________

12a. Molecular 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

12b. 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

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