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

Form B2: Contact follow-up reporting form – for close contacts (Day 14-21)

COMMENT: Information in this form may already have been completed in the Case Minimum Data Reporting Form (Form B2). It is therefore not necessary to repeat any data in these sections that has already been completed.

Confirmed Case ID / Cluster Number (if applicable):

Contact ID Number (C…):

Name of confirmed case:

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

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

3. Exposure Information **(if the close contact is NOT a HealthCare Worker)**		
Type of contact	□ Household □ Health Care workers □ Other, specify: _____	
State dates of contact and duration of contact with the confirmed case from first contact, while the primary case was **symptomatic** (Add as many dates, as required)	Date	__/__/___(dd/mm/yyyy)
	Duration	_____(mins)
	Setting	□ Home/ household □ Hospital / health care □ Workplace □ Tour group □ Other, specify:_____
State dates of contact and duration of contact with the	Date	__/__/___ (dd/mm/yyyy)

confirmed case from first contact, while the primary case was **asymptomatic** (Add as many dates, as required)	Duration	_____(mins)
	Setting	□ Home/ household □ Hospital / health care □ Workplace □ Tour group □ Other, specify: _____

4a. Symptoms in contact	
Has the contact experienced any respiratory symptoms (sore throat, cough, running nose, shortness of breath) in the period from 10 days before onset in the confirmed case until the present?	□ Yes □ No
Has the contact experienced any respiratory symptoms (sore throat, cough, running nose, shortness of breath) in the period up to 10 days after last contact or until the present date, whichever is the earliest?	□ Yes □ No
Currently ill	□ Yes □ No
Please only complete following section if contact has demonstrated symptoms since last follow up:	
Date and time of first symptom onset	___/___/___ □ AM □ PM
Maximum temperature	____^{o}C □ NA
Fever (>38^{o}C) or history of fever	□ Yes □ No □ Unknown If Yes, dates (dd/mm/yyyy - dd/mm/yyyy) ___/___/___ - ___/___/___
4b. Respiratory symptoms	
Sore throat	□ Yes □ No □ Unknown If Yes, dates (dd/mm/yyyy - dd/mm/yyyy) ___/___/___ - ___/___/___
Cough	□ Yes □ No □ Unknown If Yes, dates (dd/mm/yyyy - dd/mm/yyyy) ___/___/___ - ___/___/___
Runny nose	□ Yes □ No □ Unknown
Shortness of breath	□ Yes □ No □ Unknown If Yes, dates (dd/mm/yyyy - dd/mm/yyyy) ___/___/___ - ___/___/___
4c. 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:

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

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6a. 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

6b. 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

7. Final contact classification (at final follow-up)	
Please mark	□ Never ill/ not a case □ Confirmed secondary case □ Lost to follow-up □ Suspected case □ Probable case

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