I-NEDSS FIELD FORM

CORONAVIRUS NOVEL 2019

_____

PATIENT NAME

Investigator: _____	**Date Report Taken** _____

Demographics

Name of Patient:			
Type of ID #:			
Date of Birth:	___/___/_____		
Current Age:			
Sex:	Male	Female	Unknown
Ethnicity:	Hispanic / Latino	Not Hispanic / Not Latino	Unknown / Unclassified
Deceased:	Yes	No	Unknown
Deceased Date:	___/___/_____		
Parent/Guardian Name:			
Communicates in English	Yes	No	Unknown
Primary Language			
Race(s)	American Indian or Alaskan Native Native Hawaiian or Other Pacific Islander Asian	Black White Unknown	
Home Phone:			
Work Phone:			
Cell Phone:			
Phones Comment:			
Address Type:	Home Alcohol or Drug treatment Facility Federal Prison Foster Home Group Home Homeless Homeless shelter	Hospital Based Facility Juvenile Correctional Facility Local Jail Mental Health Facility Migrant Farm Camp Military Facility Nursing home	Other Correctional Facility Other Long Term Care Facility Other Residential Facility Other School Single Resident Facility State Prison University or College
Facility Name:			
Address Line 1:			
Address Line 2:			
City/State/Zip:			

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County: (Required)	
Country:	

General Illness

Physician Name:			
Physician Address:			
Physician City/State/Zip:			
Was patient seen in ER?	Yes	No	Unknown
ER Hospital Name & Address:			
Admitted to hospital?	Yes	No	Unknown
Same as ER hospital?	Yes	No	Unknown
If not same, name hosp.:			
Admission date:	__/__/____		
Discharge date:	__/__/____		
Duration of stay:			
Disease/Onset date:	__/__/____		
Diagnosis date:	__/__/____		
Date patient sought initial medical evaluation:	__/__/____		
Location where first seen:			
Is the patient pregnant? (Required of females with the age of onset between 8 & 60)	Yes	No	Unknown
Estimated due date:	__/__/____		
Calculated based on:			
If the patient died, was death due to the disease or condition under investigation?	Yes	No	Unknown

Clinical

Patient Status:	Still symptomatic, at home	Still symptomatic, hospitalized	Symptoms resolved	Unknown
Patient Status As Of: (mm/dd/ccyy)	__/__/____			
Fever (>100.4 F or >38 C):	Yes	No	Unknown	
Highest Temperature:	_____°F			
First Date Fever Present: (mm/dd/ccyy)	__/__/____			
Cough:	Yes	No	Unknown	

Sore Throat:	Yes	No	Unknown
Shortness of Breath:	Yes	No	Unknown
Headache:	Yes	No	Unknown
Chills:	Yes	No	Unknown
Muscle Aches:	Yes	No	Unknown
Diarrhea (3 or more loose or watery stools in 24 hours):	Yes	No	Unknown
Vomiting:	Yes	No	Unknown
Abdominal Cramps:			
Feverish (Temperature not taken):	Yes	No	Unknown
Rigors	Yes	No	Unknown
Loss of Taste and/or Smell	Yes	No	Unknown
Fatigue	Yes	No	Unknown
Other Symptoms:			
Pneumonia (clinical diagnosis):	Yes	No	Unknown
Pneumonia (radiographically consistent w/ Pneumonia):	Yes	No	Unknown
Acute Respiratory Distress Syndrome (ARDS):	Yes	No	Unknown
Renal Failure:	Yes	No	Unknown
Was the patient started on dialysis?	Yes	No	Unknown
Comorbid Conditions:	Cardiac disease Chronic pulmonary disease Former smoker Pregnancy Unknown	Chronic kidney disease Current smoker Hypertension Other: _____	Chronic liver disease Diabetes Immunocompromised None

Treatment and Immunization

Isolation/Quarantine Information

Isolation Status:	Isolated at Home	Isolated at Hospital	Release from Isolation	Deceased
Was the patient requested to self-quarantine at home?	Yes	No		Unknown
Did the patient complete home quarantine?	Yes	No		Unknown

Treatment Information

Was the patient hospitalized in the Intensive Care Unit?	Yes	No	Unknown
Was the patient on a ventilator?	Yes	No	Unknown
Was the patient intubated?	Yes	No	Unknown
Was the patient on ECMO?	Yes	No	Unknown

If hospitalized, is/was the patient in a negative pressure room?	Yes	No	Unknown

Date placed in pressure room:

Date: (mm/dd/ccyy)	/ /
Was the patient placed on contact precaution?	Yes No Unknown

Date placed on contact precaution:

Date: (mm/dd/ccyy)	/ /
If hospitalized, is/was the patient in a private room?	Yes No Unknown
What PPE (Personal Protective Equipment) did healthcare personnel use when caring for the patient or obtaining specimens?	Eye protection Gloves Gown N95 mask Surgical mask None Unknown

Date when PPE was first utilized by staff:

Date: (mm/dd/ccyy)	/ /
Treatments:	

Laboratory

Were human laboratory tests conducted?	Yes	No	Unknown
Reason for Testing:	Contact to case Outbreak/congregate living exposure Traveled to an affected area	Contact to undiagnosed high-risk patient Surveillance testing Unknown	Hospitalized patient w/severe respiratory illness Symptomatic w/unknown etiology Other
Other Reason for Testing:			
Has the specimen been sent to CDC?	Yes	No	Unknown
Were any additional non-Coronavirus respiratory pathogens detected?	Yes	No	Unknown
If yes, specify:			
If yes, did the patient respond to the appropriate treatment?	Yes	No	Unknown
Specify Treatment(s):			

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Was there a diagnosis other than respiratory infection?	Yes	No	Unknown
If yes, specify:			
Did the patient have a low lymphocyte count?	Yes	No	Unknown
WBC/Leukocyte Count: (10^3 cells/microL)			
Lymphocytes:	_____%		
Did the patient have a low platelet count?	Yes	No	Unknown
Platelet Count	_____/mm3		

	1st	2nd	3rd
Specimen number:			
Specimen source:			
Specimen collection date:	___/___/_____	___/___/_____	___/___/_____
Laboratory Name:			
Laboratory Address:			
Laboratory Phone#:			
Ordering facility name:			
Ordering facility address:			
Ordering facility phone#:			
Ordering provider name:			
Ordering provider phone#			
Reason for study:			

Laboratory Results

Lab result report date:	___/___/_____	___/___/_____	___/___/_____
Test type(s):			
Test method:			
Lab result – Organism identified:			
Lab test result:			
Lab measured result (in units):			
Reference range:			
Lab comment:			

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Contact Information			
Number of Household Members: (including Case)			
Name of Contact:			
Alias first & last name:			
Date of Birth:	___/___/_____		
Sex:			
Ethnicity:	Hispanic/Latino	Not Hispanic/Not Latino	Unknown/Unclassified
Races:	American Indian or Alaskan Native	Black	Asian
	Native Hawaiian or Other Pacific Islander	White	Unknown
Does contact have the same **home phone** as case?	Yes	No	Unknown
Home Phone:			
Work Phone:			
Cell Phone:			
Phone Comments:			
Does contact **live** at the same address as the case?	Yes	No	Unknown
Address Type:	Home	Hospital Based Facility	Other Correctional Facility
	Alcohol or Drug Treatment Facility	Juvenile correctional Facility	Other Long Term Facility
	Federal Prison	Local Jail	Other Residential Facility
	Foster Home	Mental Health Facility	Other School
	Group Home	Migrant Farm Camp	Single Residential Facility
	Homeless	Military Facility	State Prison
	Homeless Shelter	Nursing home	University or College
Address Line 1:			
Address Line 2:			
City/State/Zip:			
County:			
Country:			

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Contact occupation:	Animal Care & Service Worker	Health Care Worker	Residential Facility Worker
	Animal Control	Hospitality Industry Worker	Retail (Non-Food) Worker
	Boat Crew	Janitorial Worker	Sensitive Occupation Volunteer
	Child Care Worker	Laboratorian	Teacher
	Construction Worker	Landscaping Worker	Tourism Worker
	Correctional Worker	Livestock Worker	Transportation Worker (Other)
	Day Care Worker	Medical Waste Disposal	U.S. Military
	Dentist Or Dental Assistant	Office Worker	Veterinary Field
	Factory Worker	Personal Care And Service Worker	Wildlife worker
	Farmer/Rancher	Plumber	Non-sensitive occupation
	First Responder	Postal Worker	Other: _____
	Flight Crew	Protective Services Worker	None
	Food Service Worker	Religious Worker	
Restricted:	Yes	No	Unknown
Immunization referrals for contact?	Yes	No	Unknown
Relation to Case:	Co-worker	Household Member(nonsexual)	Needle-Sharing Partner
	Healthcare Provider	Infant under 2 years born to case	Sexual Partner
Was the contact ill with fever and/or respiratory symptoms?	Yes	No	Unknown
Onset date:	___/___/_____		
Contact comment:			

Epidemiologic Data			
Is this case part of an Outbreak?	Yes	No	Unknown
Outbreak ID:			

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PATIENT NAME

Patient occupation:	Animal Care & Service Worker	Health Care – direct Care	Religious Worker
	Animal Control	Health Care –other (env., office, security)	Retail (Non-Food) Worker
	Boat Crew	Hospitality Industry Worker	Sensitive Occupation
	Child Care Worker	Janitorial Worker	Volunteer
	Construction Worker	Laboratorian	Teacher
	Correctional Worker	Landscaping Worker	Tourism Worker
	Day Care Worker	Livestock Worker	Transportation Worker (Other)
	Dentist Or Dental Assistant	Medical Waste Disposal	U.S. Military
	Factory Worker	Office Worker	Veterinary Field
	Farmer/Rancher	Personal Care And Service Worker	Wildlife worker
	First Responder	Plumber	Non-sensitive occupation
	Flight Crew	Postal Worker	Other: _____
	Food Service Worker	Protective Services Worker	None
Name of Employer:			
Employer Address:			
Employer City/State/Zip:			
Patient attends/resides in:	College or University	Prison or Jail	Unknown
	Daycare Center	Residential Facility	Other: _____
	Preschool	School K-12	
Daycare/Facility Name:			
Date Investigation Initiated: (mm/dd/ccyy)	___/___/_____		
Date Patient/Proxy interview completed to answer the I-NEDSS module questions: (mm/dd/ccyy)	___/___/_____		
Were referrals made as appropriate for services and/or treatment?	Yes	No	Unknown
Was educational information provided on disease containment?	Yes	No	Unknown

(In the 14 days prior to Onset Date)

Did the patient have close contact [approx. 6 feet] with an ill patient who was confirmed or suspected to have Coronavirus?	Yes	No	Unknown
If yes, contact type?	Community Healthcare setting Other	Domestic travel Household Sexual	Foreign travel No travel
Describe Contact:			
Did the patient have close contact with another person who traveled to an area in the world where Coronavirus is circulating?	Yes	No	Unknown
If yes, where (country):			
Date of First Exposure: (mm/dd/ccyy)	/ /		
Date of Last Exposure: (mm/dd/ccyy)	/ /		
In the 14 days prior to illness onset, was the patient in a hospital for any reason? (i.e., visiting, working or for treatment)	Yes	No	Unknown
Name of Hospital:			
City:			
State:			
Country:			
In the 14 days prior to illness onset, was the patient in a clinic or a doctor's office for any reason?	Yes	No	Unknown
Name of Clinic/Office:			
City:			
State:			
Country			
In the 14 days prior to illness onset, did the patient have any contact with animals (e.g pets, wildlife, life stork or other animals) either at their home or away from home, including work?	Yes	No	Unknown
If yes, animal species:			

If yes, number of animals:			
If yes, where are animals located?			
In the 14 days prior to illness onset, did the patient visit any live animal markets?	Yes	No	Unknown
If yes, most recent visit/exposure			
If yes, location of market			
How was the case identified?	Active Monitoring via State/Local HD Emergency Room/Hospital/Outpatient clinic	Contact with a suspected/known case of Coronavirus Other	DHS Airport Risk Assessment
If other, specify:			
CDC Case ID:			
Final Outcome:	Determined not a PUI PUI testing completed - Case	PUI testing Pending Surveillance Testing Completed – Positive	PUI testing completed - Not A Case Surveillance Testing Completed – Negative

IDPH Only

If traveler through DGMQ, CDC notified of traveler status?	Yes	No
Date CDC Notified: (mm/dd/ccyy)	__/__/____	
If not a resident of Illinois, traveler state has been notified?	Yes	No
Date Other State Notified: (mm/dd/ccyy)	__/__/____	
Reported to Press:	Yes	No
Date Reported to Press: (mm/dd/ccyy)	__/__/____	
Epi Comment:		

Travel History

(In the 14 days prior to Onset Date)

Did the patient travel prior to onset?	Yes	No	Unknown

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Patient Name

Was the patient/contact in a country with widespread 2019 Novel Coronavirus transmission within 14 days with No known exposures?	Yes	No	Unknown	
If yes, is this an airport-screened contact?	Yes	No	Unknown	
If yes, CDC DGMQ ID #:				
Was the patient/contact put under quarantine?	Yes	No	Unknown	

Contact Details

Did the patient have any unusual or significant travel within Illinois prior to onset?	Yes	No	Unknown	
When did the patient depart for travel within Illinois? (mm/dd/ccyy)	___/___/_____			
When did the patient return from travel within Illinois? (mm/dd/ccyy)	___/___/_____			
Where did the patient go within Illinois?				
Mode of Transportation:	Boat Private plane	Bus Taxi/Limousine	Commercial plane Train	Private car Other:
Travel Details: (please include exact location of travel, airline, flight number, date, time)				
Did the patient travel outside Illinois but within the U.S. prior to onset?	Yes	No	Unknown	
When did the patient depart for travel outside Illinois but within the US? (mm/dd/ccyy)	___/___/_____			
When did the patient return from travel outside Illinois but within the US?(mm/dd/ccyy)	___/___/_____			
Where did the patient go outside Illinois but within the US?				
Mode of Transportation:	Boat Private plane	Bus Taxi/Limousine	Commercial plane Train	Private car Other: _____

Travel Details: (please include exact location of travel, airline, flight number, date, time)				
Did the patient travel outside the U.S. prior to onset?	Yes	No	Unknown	
When did the patient depart for travel outside the U.S.? (mm/dd/ccyy)	___/___/_____			
When did the patient return from travel outside the U.S.? (mm/dd/ccyy)	___/___/_____			
Where did the patient go outside the U.S.?				
Mode of Transportation:	Boat Private plane	Bus Taxi/Limousine	Commercial plane Train	Private car Other: _____
Travel Details: (please include exact location of travel, airline, flight number, date, time)				
Comments:				

Exposure History

During the possible exposure period, did the patient: - Travel - Travel on an airplane - Travel on a cruise ship - Visit or stay in a hotel - Live in or visit a residential facility (e.g., LTCF, hospital, assisted living or DD facility) - Visit or work in a hospital - Visit a doctor's office, clinic, dialysis center or dentist office - Attend a convention or public gathering?	Yes	No	Unknown

Exposure Details

Exposure Timeframe:	14 days prior to onset	14 days after onset
Potential Source of Exposure:		

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Reason for Exposure:	Resident Dental Office – patient Employee Patron Unknown	Hospital In-patient MD office – patient Visitor Passenger	Hospital Out-patient Dialysis Center – patient Student Other: _____
Date of First Exposure: (mm/dd/ccyy)	___/___/_____		
Date of Last Exposure: (mm/dd/ccyy)	___/___/_____		

List name and address information of the potential source of exposure.

Name:	
Address:	
County:	
Country:	
Phone Number:	

Reporting Source

Earliest Report Date:	___/___/_____
Date LHD Received:	___/___/_____
Reporter Name: (individual who first reported the case)	
Reporter Phone Number:	
Reporter Comments:	
Reporting Organization Name:	
Address:	
County:	
Country:	
Phone Number:	

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Miscellaneous Comments: