Date of Reporting: _____ Region: _____ Parish: _____
Doctor: _____ Hospital / Site: _____ Ward: _____
Email: _____ Phone #: _____

Hospital/Medical Record Number: _____ NEW CASE ☐ UPDATE ☐
Last Name: _____ First Name: _____
Date of Birth: _____ Age: _____ Sex: MALE ☐ FEMALE ☐
Country of Residence: _____ Parish: _____ Community: _____
Street #: _____ Street Name: _____

Epidemiologic Week of Onset: _____ Date of Onset of Illness: _____ Admission Date: _____

CLINICAL & EPIDEMIOLOGICAL PROFILE

CLINICAL PROFILE

History of Fever or Fever over 38ºC (<10 days)						Yes	No	Recorded temperature _____ ºC		
Cough	Yes	No	Difficulty Breathing/Wheezing			Yes	No	Abnormal Lung Auscultations	Yes	No
Rhinorrhoea	Yes	No	Dyspnea/ Tachypnea			Yes	No	Abnormal lung x-ray findings	Yes	No
Sore Throat	Yes	No	Diarrhoea			Yes	No	Seizure	Yes	No
Shortness of Breath	Yes	No	Nausea/Vomiting			Yes	No	Other, please specify:		
Loss of smell (Anosmia)	Yes	No	Headache			Yes	No			
Loss of Taste (Ageusia)	Yes	No	Myalgia			Yes	No			

RISK FACTORS

Pregnancy	Yes	No	Lung Disease including COPD			Yes	No	Immunocompromised due to disease or treatment	Yes	No
If yes, Trimester	1	2	3	Asthma		Yes	No	HIV / AIDS	Yes	No
Diabetes Mellitus	Yes	No	Neurological Disease			Yes	No	Malignancy	Yes	No
Sickle Cell Disease	Yes	No	Liver Disease			Yes	No	Hypertension	Yes	No
Heart Disease	Yes	No	Renal Disease			Yes	No	Obesity	Yes	No

EPIDEMIOLOGICAL PROFILE

Occupation Health Care Worker☐ Health Laboratory Worker☐ Working with Animals☐ Student☐ Other, please specify:

CONTACT HISTORY

In the 14 days before symptom onset, did the individual: Have close contact[3] with a person who is under investigation for COVID-19?	☐Y ☐N ☐Unknown
Have close contact[3] with a laboratory-confirmed COVID-19 case?	☐Y ☐N ☐Unknown
If yes: Where: Home☐ Work☐ Health Care Setting☐ Other, please specify: _____	☐Y ☐N ☐Unknown
Was the contact ill at the time of contact?	☐Y ☐N ☐Unknown
In which country was the contact diagnosed with COVID-19? _____	☐Y ☐N ☐Unknown

Contact's Name: _____

Close Contact with a person with acute respiratory infection in the 14 days prior to onset of symptoms If yes, where: Home☐ Work☐ Health Care Setting☐ Other, please specify:	Yes	No	Animal Contact If yes, please specify:	Yes	No

Fever (> 38 °C) may not be present in some patients, such as those who are very young, elderly, immunosuppressed, or taking certain medications. Clinical judgement should be used to guide testing of patients in such situations

A contact *is a person: - Providing direct care for Confirmed(Test Positive) Cases, working with health care workers infected with novel coronavirus, visiting patients or staying in the same close environment of a Positive patient; Working together in close proximity or sharing the same classroom environment with a Test Positive patient - Traveling together with a Test Positive patient in any kind of conveyance; Living in the same household as a Test Positive patient within a 14 day period after the onset of symptoms in the case under consideration.*

TRAVEL HISTORY

In the 14 days before symptom onset, did the individual: ☐Y ☐N ☐Unknown

Travel to Jamaica from another Country:

If Yes,

Country .....Province/City.....Departure Date .....

Country .....Province/City.....Departure Date .....

Admitted to ICU: Yes ☐ No ☐ If Yes, Date admitted to ICU: _____ Date Discharged from ICU: _____

Mechanical Ventilation: Yes ☐ No ☐ If Yes, Date started: _____ Date stopped: _____

Length of Ventilation (days): _____

Extracorporeal Membrane Oxygenation: Yes ☐ No ☐

LABORATORY DATA

MOLECULAR TESTING

Sample Type	Collection Date	Test Type	Results	Result Date
Nasopharyngeal ☐	Date	PCR ☐ Other (specify)	COVID-19 +ve ☐ COVID-19 -ve ☐ Other+ve ☐	
Oropharyngeal ☐	Date	PCR ☐ Other (specify)	COVID-19 +ve ☐ COVID-19 -ve ☐ Other+ve ☐	
Sputum ☐	Date	PCR ☐ Other (specify)	COVID-19 +ve ☐ COVID-19 -ve ☐ Other+ve ☐	
Other (specify)				

SEROLOGICAL TESTING

Sample Type	Collection Date	Test Type	Results	Result Date
Serum ☐	Date	IgM ☐	Positive ☐ Titre_____	
Other (specify)		IgG ☐	Negative ☐	
		Other (specify)	Inconclusive ☐	

CONTACT TRACING

Contact Type	Number of Contacts Identified	Number of Contacts Sampled
Bedroom		
Household		
Conveyance		
Health Facility		
Other(specify)		

MO(H) Signature: _____ Date: _____

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