Novel Coronavirus 2019 (COVID-19) NSW Case Questionnaire

NOTIFICATION DATE: : / / (dd/mm/yyyy) **DATE OF INTERVIEW:** / / (dd/mm/yyyy)

NCIMS ID: ..... **Interviewer name:** _____

1	Patient contact details	Family name: Given names: Street address: Suburb/ Town: State: Postcode: Country: Home phone: Mobile phone: Work phone: Email:
2	Address type	☐ Household ☐ Aged-care facility ☐ Educational Institution ☐ Assisted Living ☐ Military Barracks ☐ Prison ☐ Other ☐ Unknown If Other, please specify:
3.	Was an interpreter used?	☐ Yes ☐ No If Yes, name of interpreter and language spoken
4.	Reason for interview (tick as many as apply)	☐ Contact with known case ☐ Overseas travel ☐ Occupational exposure ☐ Reported recent risk exposure / contact ☐ Symptomatic of disease ☐ Other If Other, specify
5	Gender	☐ Male ☐ Female ☐ Unknown
6	Date of birth	Birth date: / / (dd/mm/yyyy)
7	Country of birth	
8	Indigenous Status	☐ Aboriginal origin ☐ Torres Strait Islander origin ☐ Both Aboriginal and Torres Strait Islander origin ☐ Not Aboriginal and Torres Strait Islander origin ☐ Not Stated / Unknown
RISK HISTORY - in the past 14 days		
9	Travel in the risk period	Did the person travel outside of the country/state/region in the 14 days before onset? ☐ Yes ☐ No ☐ UK Country: City / region:

		FLIGHT DETAILS: (return to Sydney) Flight Number: Seat: Arrival date: / / (dd/mm/yyyy) Departure date: / / (dd/mm/yyyy)
		Was travel with an organised tour? ☐ Yes ☐ No ☐ UK
		Type of accommodation: ☐ Private ☐ Hotel ☐ Camping ☐ Hostel ☐ Other ☐ Unknown
		- If Other, specify:
		Able to enter travel-specific details (i.e. mode of transport, flight numbers, etc.)? ☐ Yes ☐ No
		If Yes, mode(s) of transportation (check all that apply): ☐ Airplane ☐ Ship / boat / ferry ☐ Bus ☐ Train ☐ Other
		In transit / stop over? ☐ Yes ☐ No ☐ UK
10	Other Travel information	1. Date: / / (dd/mm/yyyy) Carrier: Flight # / trip #:
		Seat / cabin: Departed from: Arrived in:
		2. Date: / / (dd/mm/yyyy) Carrier: Flight # / trip #:
		Seat / cabin: Departed from: Arrived in:
		3. Date: / / (dd/mm/yyyy) Carrier: Flight # / trip #:
		Seat / cabin: Departed from: Arrived in:
		Travel Notes:
11	Contact with a known or possible case (during period of interest)	Did the case have contact with a known or possible COVID-19 case? ☐ Yes ☐ No ☐ UK
		If Yes, specify:
		Date of last contact: / / (dd/mm/yyyy)
12	Likely source of infection	☐ Acquired overseas ☐ Acquired Interstate ☐ Locally acquired - Health care associated exposure ☐ Locally acquired - Contact with a known case - other ☐ Locally acquired - Contact with a known case - household ☐ Locally acquired - Part of a known cluster – *details:* _____ ☐ Locally acquired - Source not identified ☐ Under investigation
CLINICAL PRESENTATION		
13	Onset date of first symptoms	Did the person have symptoms? ☐ Yes ☐ No ☐ UK
		- If Yes, onset date: / / (dd/mm/yyyy)
		- Duration of symptoms: (days) [if symptoms have resolved]

14	Symptoms	Acute respiratory distress syndrome ☐ Yes ☐ No ☐ UK	Confirmed by X ray? ☐ Yes ☐ No ☐ UK
		Arthralgia ☐ Yes ☐ No ☐ UK	
		Cough ☐ Yes ☐ No ☐ UK	
		Conjunctivitis ☐ Yes ☐ No ☐ UK	
		Diarrhoea ☐ Yes ☐ No ☐ UK	Diarrhoea onset date: / /
		Fatigue ☐ Yes ☐ No ☐ UK	
		Fever ☐ Yes ☐ No ☐ UK	Highest temperature: (Celsius) Where recorded
			Highest date: / /
			Feverish self-report? ☐ Yes ☐ No ☐ UK
		Chills or rigors ☐ Yes ☐ No ☐ UK	
		Headache ☐ Yes ☐ No ☐ UK	
		Malaise ☐ Yes ☐ No ☐ UK	
		Myalgia ☐ Yes ☐ No ☐ UK	
		Nausea ☐ Yes ☐ No ☐ UK	
		Pneumonia ☐ Yes ☐ No ☐ UK	Confirmed by X ray? ☐ Yes ☐ No ☐ UK
		Pneumonitis ☐ Yes ☐ No ☐ UK	
		Rhinorrhoea ☐ Yes ☐ No ☐ UK	
		Shortness of breath ☐ Yes ☐ No ☐ UK	
		Sore throat ☐ Yes ☐ No ☐ UK	
		Vomiting ☐ Yes ☐ No ☐ UK	
		Other symptoms? ☐ Yes ☐ No ☐ UK	
		- If Yes, specify symptoms:	
		Clinical notes:	
15	Clinical outcome	Was the person hospitalised? ☐ Yes ☐ No ☐ UK	
		- Name of hospital:	
		- Hospital phone number:	

		- Date admitted: / / Date discharged: / / (dd/mm/yyyy)
		Admitted to ICU/HDU? ☐ Yes ☐ No ☐ UK
		- Number of days in ICU/HDU: (days)
		Oxygen therapy required? ☐ Yes ☐ No ☐ UK
		Intubation required? ☐ Yes ☐ No ☐ UK
		Mechanical ventilation required? ☐ Yes ☐ No ☐ UK
		Hospital medical record/chart number:
16	Has the person died?	What was the outcome of the case? ☐ Alive ☐ Died
		- If Died, date of death: / / (dd/mm/yyyy)
		- Cause of death due to COVID-19 infection? ☐ Yes ☐ No ☐ UK
		- If death due to other cause, specify:
17	Admitting doctor details	Is the Admitting Doctor same as treating doctor? ☐ Yes ☐ No ☐ UK
		If Yes, enter details in the Treating Doctor section below if required.
		If No, Admitting Doctor's name:
		- Phone number / pager
18	Treating Doctor's details	Treating Doctor's name:
		Practice name (if any):
		Address:
		State: Postcode:
		Phone / pager number: Fax number:
		Email address:
19	Outcome of illness	What was the outcome of the case? ☐ Alive ☐ Died
		- If Died, date of death: / / (dd/mm/yyyy)
		- Cause of death due to COVID-19 infection? ☐ Yes ☐ No ☐ UK
		- If death due to other cause, specify:
20	Pre-existing conditions and medical history	No risk medical condition ☐ Yes ☐ No ☐ UK
		Cardiac disease (not simple hypertension) ☐ Yes ☐ No ☐ UK
		Chronic lung disease ☐ Yes ☐ No ☐ UK
		Diabetes ☐ Yes ☐ No ☐ UK
		- If Yes, are they on dialysis? ☐ Yes ☐ No ☐ UK [manual entry]

		Haemoglobinopathies	☐ Yes ☐ No ☐ UK
		Immunosuppressive condition	☐ Yes ☐ No ☐ UK
		Liver disease	☐ Yes ☐ No ☐ UK
		Metabolic disease	☐ Yes ☐ No ☐ UK
		Neurological disorder	☐ Yes ☐ No ☐ UK
		Obesity	☐ Yes ☐ No ☐ UK
		Renal disease	☐ Yes ☐ No ☐ UK
		Other risk medical condition?	☐ Yes ☐ No ☐ UK
		- If Yes, specify:	
		Pre-existing medications and conditions notes:	
21	Other Risk Factors	Is the person currently pregnant or pregnant during the illness?	☐ Yes ☐ No ☐ UK
		- If Yes, number of weeks gestation at symptom onset:	(weeks)
		Are they a current smoker?	☐ Yes ☐ No ☐ UK
		- If Yes, number of pack years:	(pack/yrs)
		Do they drink alcohol?	☐ Yes ☐ No ☐ UK
		- If Yes, average number of standard drinks per week:	(SD/week)
EXPOSURE SITES			
22	Healthcare and hospital presentations	Did the case present to a hospital in the 14 days prior to onset with COVID-19 symptoms?	☐ Yes ☐ No ☐ UK
		If Yes, date of presentation to hospital:	/ / (dd/mm/yyyy)
		If Yes, give details of the presentation and illness:	
		Did the case present to a hospital during the 14 days prior to onset with other symptoms?	☐ Yes ☐ No ☐ UK
		If Yes, date of presentation to hospital:	/ / (dd/mm/yyyy)
		If Yes, give details of the presentation and illness:	
		Did the case present to any other health care facility in the 14 days prior to onset with COVID-19 symptoms (e.g. a GP practice)?	☐ Yes ☐ No ☐ UK
		If Yes, date of presentation to hospital:	/ / (dd/mm/yyyy)
		If Yes, give details of the presentation and illness:	

POSSIBLE CONTACTS – In the period from 24 hours prior to onset of symptoms to today

23 High risk occupation

During the period of interest, did the person work in any of the following high-risk occupations?

☐ Healthcare ☐ Aged-care facility ☐ Educational facility

☐ Assisted Living ☐ Military institution ☐ Correctional facility

☐ No high-risk occupation ☐ Other ☐ Unknown

If Other, specify:

Date last attended this work: / / (dd/mm/yyyy)

Was the infection likely acquired in the workplace? ☐ Yes ☐ No ☐ UK

Description of occupation:

Employer/Facility details:
Address:
State: Postcode:
Phone number: Fax number:

Employer Contact name:

Contact email address:

24 High Risk settings

While infectious, did they visit any of the following venues or locations?

Doctor's rooms/ clinic / emergency department	☐ Y ☐ N ☐ UK
Schools / universities / TAFE	☐ Y ☐ N ☐ UK
Aged care facilities / assisted living	☐ Y ☐ N ☐ UK
Transport (plane / train / bus / ship)	☐ Y ☐ N ☐ UK
Concert venue / theatre / conference	☐ Y ☐ N ☐ UK
Office / workplace	☐ Y ☐ N ☐ UK
Other public venue / gathering	☐ Y ☐ N ☐ UK

If yes, give details:

25	Close contacts	While infectious, did they have close contact with any of the following: □ family members □ housemates □ friends
		If yes, give details (including name, phone number, email address):