Michigan Interim 2019 Novel Coronavirus (COVID-19)
Person Under Investigation (PUI)/Case Report Form Cover Sheet

The MDHHS Bureau of Laboratories (BOL) is continuing with testing of specimens for suspected COVID-19. Now that more commercial and clinical laboratories are coming online with testing, the best use of this valuable resource at the MDHHS BOL is in the testing of specimens of greatest public health significance. The MDHHS BOL will test specimens for patients meeting one of the priority categories below. These groups represent individuals for whom public health intervention is critical. The rapid integration of investigative information with laboratory results allows for the most effective public health action toward mitigating transmission.

Most patients with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (e.g., cough, difficulty breathing). Clinicians are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza. Please use the attached Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form. If you are a healthcare provider with a suspect COVID-19 PUI meeting one of the priority categories below, please call the:

Michigan COVID-19 Laboratory Emergency Response Network (MI-CLERN) at: 888-277-9894

MDHHS BOL Priority Testing Categories include specimens from:

1. **Individuals presenting with signs/symptoms of COVID-19 infection who are identified as a known contact of a confirmed case of COVID-19 infection and are not members of the same household or congregate living situation as the confirmed case (unless as part of a public health investigation).**
2. **Individuals who become symptomatic while in a 14-day monitoring and quarantine period (such as, but not limited to, monitoring due to travel from a region with widespread transmission).**
3. **Symptomatic individuals who are part of a public health investigation of a cluster of illness associated with a vulnerable population (e.g., long term care facility).**
4. **Symptomatic individuals who may be more likely to infect many of people or a vulnerable population (e.g., healthcare providers and those living in congregate settings like dorms, camps, long term care facilities).**
5. **Individuals presenting with severe illness requiring hospitalization or causing mortality and having no other identified etiology.**

After approval by MI-CLERN for MDHHS BOL submission:

- Fax the completed PUI form to the local health department of patient residence
- Submit a completed DCH-0583 Microbiology/Virology form and completed PUI form with the specimen(s) to the MDHHS BOL. A Nasopharyngeal (NP) swab is the preferred specimen. The NP swab must be collected by a health care provider
- **The PUI (nCoV) ID must be written on all forms submitted to the MDHHS BOL**

Specimens for COVID-19 testing on individuals not meeting one of the five MDHHS BOL priority categories should be directed to commercial or clinical labs for testing. **PUI (nCoV) IDs do not need to be assigned for specimens being submitted to clinical or commercial labs.**

For additional information about 2019 Novel Coronavirus (COVID-19), please see: https://www.cdc.gov/coronavirus/2019-ncov/index.html and https://www.michigan.gov/coronavirus

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Patient Information:

First name:_____ Last name: _____

Date of birth:_____/_____/_____ Age: _____ Sex: ☐ Female ☐ Male

Patient residence street address:_____City: _____

County: _____ State: _____ Zip Code: _____

Patient phone number(s):_____/_____

Patient hospital ID (Medical Record) number: _____

Submitting Facility Information:

Reporting healthcare facility: _____

Reporting healthcare facility contact name and title: _____

Healthcare facility contact phone number: _____

Please provide reason for testing:

☐ Individuals presenting with signs/symptoms of COVID-19 infection who are identified as a known contact of a confirmed case of COVID-19 infection and are not members of the same household or congregate living situation as the confirmed case (unless as part of a public health investigation).

☐ Individuals who become symptomatic while in a 14-day monitoring and quarantine period (such as, but not limited to, monitoring due to travel from a region with widespread transmission).

☐ Symptomatic individuals who are part of a public health investigation of a cluster of illness associated with a vulnerable population (e.g., long term care facility).

☐ Symptomatic individuals who may be more likely to infect many of people or a vulnerable population (e.g., healthcare providers and those living in congregate settings like dorms, camps, long term care facilities).

☐ Individuals presenting with severe illness requiring hospitalization or causing mortality and having no other identified etiology.

Specimen being tested at:

☐ MDHHS BOL PUI (nCoV) ID#: MI-_____ (Required)

A PUI (nCoV) ID # must be assigned by the MI-CLERN provider hotline (888-277-9894) prior to specimens being submitted from a healthcare facility to the MDHHS BOL for COVID-19 testing.

☐ Clinical or Commercial lab. A PUI (nCoV) ID is not required.

Version date: 03/18/2020

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ____/_____/_____

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……

Human Infection with 2019 Novel Coronavirus
Person Under Investigation (PUI) and Case Report Form

Reporting jurisdiction: _____ Case state/local ID: _____
Reporting health department: _____ CDC 2019-nCoV ID: _____
Contact ID [a]: _____ NNDSS loc. rec. ID/Case ID [b]: _____

a. Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case CA102034567 has contacts CA102034567 -01 and CA102034567 -02. [b]For NNDSS reporters, use GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Last _____ First_____

Affiliation/Organization: _____ Telephone _____ Email _____

Basic information

What is the current status of this person?
- ☐ PUI, testing pending*
- ☐ PUI, tested negative*
- ☐ Presumptive case (positive local test), confirmatory testing pending†
- ☐ Presumptive case (positive local test), confirmatory tested negative†
- ☐ Laboratory-confirmed case†

*Testing performed by state, local, or CDC lab.
†At this time, all confirmatory testing occurs at CDC

Report date of PUI to CDC (MM/DD/YYYY):
____/_____/_____

Report date of case to CDC (MM/DD/YYYY):
____/_____/_____

County of residence: _____
State of residence: _____

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/ Latino
- ☐ Not specified

Sex:
- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ Other

Race (check all that apply):
- ☐ Asian
- ☐ Black
- ☐ White
- ☐ Other, specify: _____
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Unknown

Date of birth (MM/DD/YYYY): ____/_____/_____
Age: _____
Age units(yr/mo/day): _____

Date of first positive specimen collection (MM/DD/YYYY):
____/_____/_____
☐ Unknown ☐ N/A

Did the patient develop pneumonia?
☐ Yes ☐ Unknown ☐ No

Did the patient have acute respiratory distress syndrome?
☐ Yes ☐ Unknown ☐ No

Did the patient have another diagnosis/etiology for their illness?
☐ Yes ☐ Unknown ☐ No

Did the patient have an abnormal chest X-ray?
☐ Yes ☐ Unknown ☐ No

Was the patient hospitalized?
☐ Yes ☐ No ☐ Unknown

If yes, admission date 1
___/___/___ (MM/DD/YYYY)
If yes, discharge date 1
__/___/____ (MM/DD/YYYY)

Was the patient admitted to an intensive care unit (ICU)?
☐ Yes ☐ No ☐ Unknown

Did the patient receive mechanical ventilation (MV)/intubation?
☐ Yes ☐ No ☐ Unknown
If yes, total days with MV (days)
_____

Did the patient receive ECMO?
☐ Yes ☐ No ☐ Unknown

Did the patient die as a result of this illness?
☐ Yes ☐ No ☐ Unknown

Date of death (MM/DD/YYYY):
____/_____/_____
☐ Unknown date of death

Symptoms present during course of illness:
- ☐ Symptomatic
- ☐ Asymptomatic
- ☐ Unknown

If symptomatic, onset date (MM/DD/YYYY):
____/_____/_____
☐ Unknown

If symptomatic, date of symptom resolution (MM/DD/YYYY):
____/_____/_____
☐ Still symptomatic ☐ Unknown symptom status
☐ Symptoms resolved, unknown date

Is the patient a health care worker in the United States? ☐ Yes ☐ No ☐ Unknown
Does the patient have a history of being in a healthcare facility (as a patient, worker or visitor) in China? ☐ Yes ☐ No ☐ Unknown
In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):
- ☐ Travel to Wuhan
- ☐ Travel to Hubei
- ☐ Travel to mainland China
- ☐ Travel to other non-US country specify:_____
- ☐ Household contact with another lab-confirmed COVID-19 case-patient
- ☐ Community contact with another lab-confirmed COVID-19 case-patient
- ☐ Any healthcare contact with another lab-confirmed COVID-19 case-patient ☐ Patient ☐ Visitor ☐ HCW
- ☐ Animal exposure
- ☐ Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology
- ☐ Other, specify:_____
- ☐ Unknown

If the patient had contact with another COVID-19 case, was this person a U.S. case? ☐ Yes, nCoV ID of source case: _____ ☐ No ☐ Unknown ☐ N/A

Under what process was the PUI or case first identified? (check all that apply): ☐ Clinical evaluation leading to PUI determination
☐ Contact tracing of case patient ☐ Routine surveillance ☐ EpiX notification of travelers; if checked, DGMQID_____
☐ Unknown ☐ Other, specify:_____

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

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Symptoms, clinical course, past medical history and social history

Collected from (check all that apply): ☐ Patient interview ☐ Medical record review

During this illness, did the patient experience any of the following symptoms?	Symptom Present?
Fever >100.4F (38C)[c]	☐Yes ☐No ☐Unk
Subjective fever (felt feverish)	☐Yes ☐No ☐Unk
Chills	☐Yes ☐No ☐Unk
Muscle aches (myalgia)	☐Yes ☐No ☐Unk
Runny nose (rhinorrhea)	☐Yes ☐No ☐Unk
Sore throat	☐Yes ☐No ☐Unk
Cough (new onset or worsening of chronic cough)	☐Yes ☐No ☐Unk
Shortness of breath (dyspnea)	☐Yes ☐No ☐Unk
Nausea or vomiting	☐Yes ☐No ☐Unk
Headache	☐Yes ☐No ☐Unk
Abdominal pain	☐Yes ☐No ☐Unk
Diarrhea (≥3 loose/looser than normal stools/24hr period)	☐Yes ☐No ☐Unk
Other, specify:_____	

Pre-existing medical conditions? ☐ Yes ☐ No ☐ Unknown

Chronic Lung Disease (asthma/emphysema/COPD)	☐Yes	☐No	☐Unknown	
Diabetes Mellitus	☐Yes	☐No	☐Unknown	
Cardiovascular disease	☐Yes	☐No	☐Unknown	
Chronic Renal disease	☐Yes	☐No	☐Unknown	
Chronic Liver disease	☐Yes	☐No	☐Unknown	
Immunocompromised Condition	☐Yes	☐No	☐Unknown	
Neurologic/neurodevelopmental/intellectual disability	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Other chronic diseases	☐Yes	☐No	☐Unknown	(If YES, specify) _____
If female, currently pregnant	☐Yes	☐No	☐Unknown	
Current smoker	☐Yes	☐No	☐Unknown	
Former smoker	☐Yes	☐No	☐Unknown	

Respiratory Diagnostic Testing

Test	Pos	Neg	Pend.	Not done
Influenza rapid Ag ☐ A ☐ B	☐	☐	☐	☐
Influenza PCR ☐ A ☐ B	☐	☐	☐	☐
RSV	☐	☐	☐	☐
H. metapneumovirus	☐	☐	☐	☐
Parainfluenza (1-4)	☐	☐	☐	☐
Adenovirus	☐	☐	☐	☐
Rhinovirus/enterovirus	☐	☐	☐	☐
Coronavirus (OC43, 229E, HKU1, NL63)	☐	☐	☐	☐
M. pneumoniae	☐	☐	☐	☐
C. pneumoniae	☐	☐	☐	☐
Other, Specify:_____	☐	☐	☐	☐

Specimens for COVID-19 Testing

Specimen Type	Specimen ID	Date Collected	State Lab Tested	State Lab Result	Sent to CDC	CDC Lab Result
NP Swab			☐		☐	
OP Swab			☐		☐	
Sputum			☐		☐	
Other, Specify: _____			☐		☐	

Additional State/local Specimen IDs: _____ _____ _____ _____ _____