Appendix 1: Severe Acute Respiratory Infection Case Report Form
COVID-19 Follow-Up Form

Client Demographics		**Notice of Collection Date:**
Last Name:		First Name:
Date of Birth: DD-MMM-YYYY	Age:	Gender: Male ☐ Female ☐ Other ☐ Specify:
Address:		Health Card Number:
City:	Postal Code:	Phone: Home: Cell: Work:
Email:		
Occupation:		Health Care Worker? ☐ Yes ☐ No
Workplace/School:		Workplace/School Address:
Next of Kin:		Relationship / Phone: Home: Cell: Work:
Family Physician/HCP:		HCP Phone Number:

Reporting Information	**Date reported to Health Unit:** DD-MMM-YYYY
Contact information of CHN reporting	Phone Number:

Laboratory Results				
Specimen Type	Testing Lab (PHOL or NML)	Collection Date	Result	Date of laboratory Result:
		DD-MMM-YYYY		DD-MMM-YYYY
		DD-MMM-YYYY		DD-MMM-YYYY
		DD-MMM-YYYY		DD-MMM-YYYY

Case Classification ****CHN must complete SARI Form and report to CD nurse and PHU who reports to ministry. Ministry must report to PHAC within 24hrs of identification. See PH Management documents for details****	
Person Tested ☐ High index of suspicion for becoming a case (i.e. had high risk exposure – close contact, travel) ☐ Clinician has ordered COVID-testing; patient does not have high index of suspicion for becoming case	Date: DD-MMM-YYYY
Probable Case	Date: DD-MMM-YYYY
Confirmed Case	Date: DD-MMM-YYYY

Admitted to Hospital: ☐ Yes ☐ No			
Name of Hospital:		Room Number:	
Date admitted:	DD-MMM-YYYY	Date Discharged:	DD-MMM-YYYY
ICU:	☐ Yes ☐ No	Isolation precautions:	☐ Yes ☐ No
Oxygen Therapy:	☐ Yes ☐ No	Ventilator:	☐ Yes ☐ No

Signs and Symptoms *Symptoms to be monitored on daily clinical update form*		**Onset Date:** DD-MMM-YYYY **Date of Death:** DD-MMM-YYYY	
☐ No symptoms	☐ Swollen lymph nodes	☐ Shortness of breath/ difficulty breathing	☐ Nose bleed
☐ Fever (≥38°C)	☐ Sneezing	☐ Chest pain	☐ Rash
☐ Feverish/chills (temp not taken)	☐ Conjunctivitis	☐ Anorexia/decreased appetite	☐ Seizures
☐ Cough	☐ Otitis	☐ Nausea	☐ Dizziness
☐ Sputum production	☐ Fatigue/prostration	☐ Vomiting	☐ Arthralgia/joint pain
☐ Headache	☐ Malaise/chills	☐ Diarrhea	☐ Sore throat
☐ Rhinorrhea/nasal congestion	☐ Myalgia/muscle pain	☐ Abdominal pain	☐ Other

Exposure - Travel

In the past 14 days, did the patient travel outside of Ontario or Canada?
☐ Yes ☐ No ☐ Unknown

Province/ Country Visited	Area in Province / Country	Hotel or Residence	Dates of Travel

In the past 14 days, did the patient travel on a plane or other public transportation?
☐ Yes ☐ No ☐ Unknown

Travel Type	Carrier Name	Flight/ carrier #	Seat #	Departure (City, Country)	Arrival (City, Country)	Date of Travel

Exposure – Human

In the past 14 days, did the client come in close contact (cared for, lived for, spent significant time within closed quarters or had direct contact with respiratory secretions) **with:**

A confirmed case of COVID-19?

☐ Yes ☐ No ☐ Unknown *case ID of contact:*

A probable case of COVID-19?

☐ Yes ☐ No ☐ Unknown *case ID of contact:*

Close contact with a person with acute respiratory illness who has travelled outside of the province of Ontario or Canada?

☐ Yes - *Please specify area of travel:* ☐ No ☐ Unknown

Treatment Initiated ☐ Yes ☐ No

Drug	Dose	Unit	Frequency	Route	Start Date:	End Date:	Comments
					DD-MMM-YYYY	DD-MMM-YYYY	
					DD-MMM-YYYY	DD-MMM-YYYY	
					DD-MMM-YYYY	DD-MMM-YYYY	

Medical Risk Factors	**None Identified:** ☐	
☐ Anemia or hemoglobinopathy	☐ Immunocompromised (Specify):	☐ Other (specify):
☐ Asthma	☐ Neurologic disorder (Specify):	
☐ Cancer (Specify):	☐ Obesity	
☐ Cardiovascular condition	☐ Post-partum (≤6 weeks)	
☐ Chronic illness/underlying medical condition	☐ Pregnant	
☐ Chronic liver disease:	☐ Renal condition	
☐ COPD	☐ Tuberculosis	
☐ Diabetes	☐ Unknown	

Behavioural Risk Factors	**None Identified:** ☐
☐ Alcohol abuse	☐ Occupational – veterinarian
☐ Close contact with a case	☐ Resident of nursing home or other chronic care facility
☐ Contact with animals	☐ Smoker - Specify number of cigarettes smoked per day: _____
☐ Injection drug use	☐ Travel outside province in the last 14 days (specify province or country):
☐ Occupational - animal or animal product handler	☐ Visited a health care facility within the last 14 days:
☐ Occupational – farm worker	☐ Unknown
☐ Occupational – health care worker	☐ Other (specify):
☐ Occupational – laboratory worker	☐

Complications	None Identified: ☐
☐ Altered mental status	☐ O2 saturation ≤95%
☐ Acute respiratory distress syndrome	☐ Palpitations/arrhythmia
☐ Breathing rapid (tachypnea)	☐ Pneumonia
☐ Encephalitis	☐ Renal failure
☐ Heart failure	☐ Respiratory failure
☐ Hypotension	☐ Sepsis
☐ Liver failure	☐ Unknown
☐ Meningismus / Nuchal rigidity	☐ Other (specify):

Contact Tracing

Contact Tracing completed on *Appendix 5: Close Contact Tracing Worksheet Form*

☐ Yes ☐ No

Comments:

Progress Notes

Date	Comments

Completed Date: DD-MMM-YYYY

CHN Investigator Name: _____

CHN Investigator Signature: _____