



MINISTRY OF
HEALTH & WELLNESS
NATIONAL SURVEILLANCE UNIT
24-26 Grenada Crescent, Kingston 5
Jamaica, West Indies
Tel: (876) 633-7925 / 8195
Email: surveillance@moh.gov.jm

2019 Novel Coronavirus (COVID-19) Case Investigation Form

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

Hospital/Medical Record Number: _____	NEW CASE <input type="checkbox"/>	UPDATE <input type="checkbox"/>
Last Name: _____	First Name: _____	
Date of Birth: _____	Age: _____	Sex: MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
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 38°C (<10 days)					Yes	No	Recorded temperature _____ °C		
Cough	Yes	No	Difficulty Breathing/Wheezing	Yes	No	Dyspnea/ Tachypnea	Yes	No	
Rhinorrhoea	Yes	No	Nausea/Vomiting	Yes	No	Abnormal Lung Auscultations	Yes	No	
Sore Throat	Yes	No	Headache	Yes	No	Abnormal lung x-ray findings	Yes	No	
Shortness of Breath	Yes	No	Myalgia	Yes	No	Seizure	Yes	No	
Other, please specify: _____						Other, please specify: _____			
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			
Sickle Cell Disease	Yes	No	Liver Disease	Yes	No	Other, please specify: _____			
Heart Disease	Yes	No	Renal Disease	Yes	No				
EPIDEMIOLOGICAL PROFILE									
Occupation Health Care Worker <input type="checkbox"/> Health Laboratory Worker <input type="checkbox"/> Working with Animals <input type="checkbox"/> Student <input type="checkbox"/> Other, please specify: _____									
Close Contact with a person with acute respiratory infection in the 14 days prior to onset of symptoms				Yes	No	Animal Contact			
If yes, where: Home <input type="checkbox"/> Work <input type="checkbox"/> Health Care Setting <input type="checkbox"/> Other, please specify: _____						If yes, please specify: _____			
Close Contact with Probable or Confirmed Case in the 14 days prior to onset of symptoms				Yes	No	Travel abroad in the 14 days prior to onset of symptoms			
If yes, where: Home <input type="checkbox"/> Work <input type="checkbox"/> Health Care Setting <input type="checkbox"/> Other, please specify: _____						Contact with traveler in past 14 days? If yes, country(ies) visited: _____ Date of departure: _____			
Visited any Health Facility in the 14 days prior to onset of symptoms				Yes	No	Other: _____			
If yes, Health Facility visited: _____									

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.



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TRAVEL HISTORY/ In the 14 days before symptom onset, did the patient:

Spend time in China? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
If Yes, Province.....City..... Departure Date
Province.....City..... Departure Date
Province.....City..... Departure Date
Province.....City..... Departure Date
Travel to another country (Not China) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
If Yes, Province/State.....City..... Departure Date
Province/State.....City..... Departure Date
Province/State.....City..... Departure Date
Have close contact ³ with a person who is under investigation for 2019-nCoV? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
Have close contact ³ with a person with laboratory confirmed 2019-nCoV? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
Have close contact ³ with a laboratory-confirmed 2019-nCoV case? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
Was the case ill at the time of contact? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
Is the case a Jamaican case? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
Is the case an international case? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
In which country was the case diagnosed with 2019 n-CoV? _____

Sample taken: Yes No Sample Type: _____ Date Sample Taken: _____

Sample taken to Lab: Yes No Date Sample Taken to Lab: _____

Laboratory Results: Virology Positive Negative Virus: _____
Bacteriology Positive Negative Bacteria: _____

Treatment Received: _____ Patient ventilated

Isolated Date: _____ Admission to ICU Date: _____

Discharged from Hospital Date: _____ Death Date: _____

Final Diagnosis: _____ MO(H) Signature: _____

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