MINISTRY OF HEALTH & WELLNESS
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**DAY 21**

# 2019 Novel Coronavirus (COVID-19) Case Follow-up Form

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

**Hospital/Medical Record Number**: _____
**Last Name:** _____ **First Name:** _____
**Date of Birth:** _____ **Age:** _____ **Sex: MALE ☐ FEMALE ☐**
**Country of Residence:** _____ **Parish:** _____ **Community:** _____

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

## CLINICAL & EPIDEMIOLOGICAL PROFILE

### CLINICAL COURSE

| CURRENT STATUS | | | | | | | |
|---|---|---|---|---|---|---|---|
| Recovered ☐ Date _____ | Max. Recorded temperature _____ºC | | | | | | |
| Still ill ☐ | **SYMPTOMS/SIGNS** | | | | | | |
| Died ☐ Date _____ | Cough | Yes | No | Headache | Yes | No |
| Unknown ☐ Date _____ | Sore throat | Yes | No | Nausea | Yes | No |
| | Runny nose | Yes | No | Vomiting | Yes | No |
| | Shortness of Breath | Yes | No | Rash | Yes | No |
| **COMPLICATIONS** | Ageusia | Yes | No | Conjunctivitis | Yes | No |
| Acute Respiratory Distress Syndrome ☐ Date | Anosmia | Yes | No | Seizures | Yes | No |
| Acute Renal Failure ☐ Date | Fatigue | Yes | No | Altered consciousness | Yes | No |
| Cardiac Failure ☐ Date | Joint Pain | Yes | No | Nosebleed | Yes | No |
| Consumptive Coagulopathy ☐ Date | Muscle Pain | Yes | No | Other signs/symptoms (specify) | | |
| Pneumonia by chest X-ray ☐ Date | Chills | Yes | No | Other signs/symptoms (specify) | | |

**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_____ | COVID-19 +ve ☐ COVID-19 -ve ☐ Other+ve ☐ | |
| Oropharyngeal ☐ | Date | PCR ☐ Other _____ | COVID-19 +ve ☐ COVID-19 -ve ☐ Other+ve ☐ | |
| Sputum ☐ | Date | PCR ☐ Other_____ | 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 ☐ | |

**MO(H) Signature:** _____ **Date:** _____

***Recovered*** *– A patient is considered recovered from COVID-19 after two successive negative RT-PCR tests.*