COVID -19 Case Investigation Form

Ministry of Health and Social Services

Laboratory Number

EPID Number: COUNTRY-RGN-DIS-YR-SEQ NO

REASONS FOR COVID-19 TESTING

URGENT/PRIORITY		ROUTINE		
☐ HOSPITALIZED PATIENT (SYMPTOMATIC)	☐ HEALTH WORKER (SYMPTOMATIC)	☐ SUSPECTED NEW CASE	☐ CONTACT	☐ ACTIVE CASE SEARCH
☐ TRAVEL (MEDICAL REASONS)	☐ TRUCK DRIVER (CROSS BORDER)	☐ EXPANDED TARGET TESTING		☐ TRAVEL (NON-MEDICAL)
☐ HOSPITAL ADMISSION / PRE-OP	☐ DECEASED	☐ CONFIRMATORY PCR TEST		☐ SUSPECTED RE-INFECTION

SPECIMEN TYPE

☐ Nasopharyngeal swab ☐ Sputum ☐ Oropharyngeal Swab ☐ Saliva ☐ other (specify):_____

TEST

☐ **PCR** ☐ **Antigen RDT** ☐ **Multiplex PCR**

Specimen Collection Date		**Date received at Laboratory**		**Date of last positive result if suspected re-infection**	

Laboratory results **Positive** ☐ **Negative** ☐ **Indeterminate** ☐ **Invalid (Repeat test)** ☐ **Rejected** ☐ Reason for rejection_____

Date of result:____/_____/_____

PATIENT DETAILS

Full Name:		ID/Passport #		DOB	(yyyy/mm/dd)	Age		Sex	M ☐ F ☐
Current Address		Nationality:		Residential Address					
Patient's contact number/s:									
Occupation:									
Name of the employer/ place of employment if self employed									
Date of consultation/admission	D D M M Y Y Y Y								

DOCTOR/HEALTH CARE PROVIDER'S DETAILS

Full Name:		Contact No:	
Email Address:			
Facility Name:			
Region:		District	

NEXT OF KIN CONTACT DETAILS

Full Name:		Relationship to the patient:	
Contact Number			

SIGNS AND SYMPTOMS (tick all that apply)

Symptomatic: **Yes/No** If Yes ☐ Fever (≥38° C) ☐ Cough ☐ Chills ☐ Sore throat ☐ Shortness of breath ☐ Vomiting ☐ Diarrhea ☐ Myalgia/body pains ☐ Loss of smell ☐ Loss of taste

☐ Other (specify if other)_____ **Date of symptom onset:** _____/_____/_____

*Physical contact with a known COVID-19 case **Yes** ☐ **No** ☐ If yes indicate name and surname (If Known) _____ **Unknown** ☐

*Travel from countries, or other areas in Namibia where there is known COVID-19 community transmission **Yes** ☐ **No** ☐ **Unknown** ☐

· **If Yes, please complete the section below:**

Country	Region	City/Town	Date of departure (travel to area)	Date of return (travel from area)
			DD MM YYYY	DD MM YYYY

VACCINATION STATUS

Is the patient vaccinated? Yes ☐ No ☐ Name of Vaccine: _____

Number of Doses: ☐ single dose vaccine ☐ 1st Dose ☐ 2nd Dose ☐ 3rd Dose ☐ Unknown Date of last vaccination: _____/_____/_____

MEDICAL HISTORY / CO-MORBIDITIES

Obesity ☐ Tuberculosis ☐ Chronic Kidney Disease ☐ Diabetes Mellitus ☐ Cardiovascular disease including Hypertension ☐ Pregnancy ☐

HIV ☐ Asthma ☐ Chronic Liver Disease ☐ COPD/Chronic Pulmonary disease ☐ Others ☐ (specify):_____

Previously tested positive for COVID -19 ? Yes ☐ No☐ If Yes add Date of confirmation: _____/____/_____

Presence of clinical or radiological pneumonia Yes☐ No☐ *Were chest X rays (CXR) done: Y ☐ N ☐ CXR Findings:_____

Presence of clinical or radiological Acute Respiratory Distress Syndrome (ARDS) Yes ☐ No ☐

Presence of another diagnosis/etiology for their respiratory illness Yes ☐ (specify)_____ No ☐ Unknown ☐

TREATMENT / MANAGEMENT

Patient Hospitalised: Yes☐ No☐ Unknown☐ Admitted to ICU: Yes☐ No☐ Unknown☐ Ventilation: Yes☐ No☐ Unknown☐

On ECMO: Yes ☐ No ☐ Unknown☐ Transferred ☐ Name of transferred facility _____

Referred ☐ Referral facility _____ Discharged ☐ Discharge date: _____/_____/_____

PATIENT OUTCOME

Active ☐ **Recovered** ☐ **Recovery date:** _____/_____/_____ **Died** ☐ **Date of Death:** _____/_____/_____

FINAL CLASSIFICATION

Laboratory Confirmed ☐ **Probable/Clinical Confirmed** ☐ **Suspected** ☐ **Not a case (Discarded)** ☐

Form completed by (Name & Surname)		**Contact details (Tel or Cell No)**		**Unit/Department**	
Signature					