nCoV ID: ____________

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

SARS-CoV-2 Reinfection Case Investigation Form

Reporting jurisdiction: ____________ **Case state/local ID:** ____________

Reporting health department: ____________ **CDC 2019-nCoV ID:** ____________

Hospital MRN: ____________

Interviewer information

Last Name: ____________ **First Name:** ____________

Affiliation/Organization: ____________

Telephone: ____________ **Email:** ____________ **Date of interview** *(mm/dd/yyyy)*: ____________

Date of medical chart abstraction *(mm/dd/yyyy)*: ____________

Data sources used for this form?

Case-patient interview   Other interview, specify relationship to case: ____________   Medical Chart Abstraction

Case-patient's primary language: ____________ **Was this form administered via a translator?** Yes No Unknown

Case-patient demographic information

1. **Age:** ______ **Age units:** Years Months Days
2. **Sex:** Male Female Other Unknown
3. **Ethnicity:** Hispanic/Latinx Non-Hispanic/Latinx Unknown
4. **Race (check all that apply):** White Asian American Indian/Alaska Native Black Native Hawaiian/Other Pacific Islander Unknown Other, specify: ____________
5. **County of Residence:** ____________ **State of Residence:** ____________
6. **Country of Residence:** United States Other, specify: ____________
7. **Occupation:** ____________
8. **Was this patient employed as a health care worker or first responder since Jan. 1st, 2020?** Yes No Unknown
9. **Was this patient a long-term care facility resident prior to initial diagnosis?** Yes No Unknown
10. **Was this patient employed in a laboratory that processes SARS-CoV-2 samples?** Yes No Unknown
11. **Has the patient visited, worked at, or resided in any of the following:**
    - Prison
    - Meat processing plant
    - Church
    - School, *specify:* Preschool K-12 College
    - Other congregate setting, describe: ____________
    - None
12. **Did the patient come into contact with a person with known SARS-CoV-2 infection in the two weeks prior to their second illness episode?**
    Yes No Unknown

First Episode

13. **Date of suspected SARS-CoV-2 reinfection positive PCR test** *(mm/dd/yyyy)*: ____________
14. **If symptomatic on 1st episode, date of symptom onset** *(mm/dd/yyyy)*: ____________ Asymptomatic Unknown

Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).

nCoV ID: ____________

15. What were the symptoms on presentation:

Symptom	Present?		
Fever ≥100.4F (38C)	Yes	No	Unknown
Subjective fever (felt feverish)	Yes	No	Unknown
Chills	Yes	No	Unknown
Rigors	Yes	No	Unknown
Muscle aches (myalgia)	Yes	No	Unknown
Runny nose (rhinorrhea)	Yes	No	Unknown
Sore throat	Yes	No	Unknown
New olfactory and taste disorder(s)	Yes	No	Unknown
Headache	Yes	No	Unknown
Fatigue	Yes	No	Unknown

Symptom	Present?		
Cough (new onset or worsening of chronic cough)	Yes	No	Unknown
Wheezing	Yes	No	Unknown
Shortness of breath (dyspnea)	Yes	No	Unknown
Difficulty breathing	Yes	No	Unknown
Chest Pain	Yes	No	Unknown
Nausea or vomiting	Yes	No	Unknown
Abdominal pain	Yes	No	Unknown
Diarrhea (≥3 loose/looser than normal stools/24hr period)	Yes	No	Unknown
Other, specify:	Yes	No	Unknown

16. What is the highest level of care received during this episode?

Self-care/Over-the-counter   Emergency department/urgent care   Intensive Care Unit
Outpatient/Telemedicine   Hospitalized   Received mechanical ventilation

17. If hospitalized, what was the length of stay (in days): ________   18. If hospitalized, date of discharge *(mm/dd/yyyy)*: ____________

19. Did the patient receive treatment for SARS-CoV-2?   Yes   No   N/A   If yes, specify: ____________

20. Did the patient recover (defined as afebrile without antipyretics AND progressive improvement/resolution of symptoms)?   Yes   No   N/A

If yes, date of recovery *(mm/dd/yyyy)*: ____________

21. Comments about 1st course of illness:

____

Second Episode

22. Date of suspected SARS-CoV-2 reinfection positive PCR test *(mm/dd/yyyy)*: ____________

23. If symptomatic on 2nd episode, date of symptom onset *(mm/dd/yyyy)*: ____________   Asymptomatic   Unknown

24. What were the symptoms on presentation:

Symptom	Present?		
Fever ≥100.4F (38C)	Yes	No	Unknown
Subjective fever (felt feverish)	Yes	No	Unknown
Chills	Yes	No	Unknown
Rigors	Yes	No	Unknown
Muscle aches (myalgia)	Yes	No	Unknown
Runny nose (rhinorrhea)	Yes	No	Unknown
Sore throat	Yes	No	Unknown
New olfactory and taste disorder(s)	Yes	No	Unknown
Headache	Yes	No	Unknown
Fatigue	Yes	No	Unknown

Symptom	Present?		
Cough (new onset or worsening of chronic cough)	Yes	No	Unknown
Wheezing	Yes	No	Unknown
Shortness of breath (dyspnea)	Yes	No	Unknown
Difficulty breathing	Yes	No	Unknown
Chest Pain	Yes	No	Unknown
Nausea or vomiting	Yes	No	Unknown
Abdominal pain	Yes	No	Unknown
Diarrhea (≥3 loose/looser than normal stools/24hr period)	Yes	No	Unknown
Other, specify:	Yes	No	Unknown

25. What is the highest level of care received during this episode?

Self-care/Over-the-counter   Emergency department/urgent care   Intensive Care Unit
Outpatient/Telemedicine   Hospitalized   Received mechanical ventilation

26. If hospitalized, what was the length of stay (in days): ________   27. If hospitalized, date of discharge *(mm/dd/yyyy)*: ____________

28. Did the patient receive treatment for SARS-CoV-2?   Yes   No   N/A   If yes, specify: ____________

29. Did the patient recover (defined as afebrile without antipyretics AND progressive improvement/resolution of symptoms)?   Yes   No   N/A

30. If symptoms are ongoing, what is the date of the last known symptoms for 2nd episode *(mm/dd/yyyy)*? ____________

31. If symptomatic, are the recurrent symptoms better explained by a non-COVID-19 etiology?   Yes   No   N/A

If yes, what laboratory evidence supports an alternative etiology: ____________

32. Does the treating physician suspect that this is a case of SARS-CoV-2 reinfection?   Yes   No   N/A

33. Comments about 2nd course of illness:

nCoV ID: ____________

Past medical history

34. Does the patient have any pre-existing medical conditions? Yes No N/A

Condtion	Present?	Details
Chronic Lung Disease	Yes No Unknown	
Asthma/reactive airway disease	Yes No Unknown	
Emphysema/COPD	Yes No Unknown	
Other chronic lung disease	Yes No Unknown	If YES, specify:
Active tuberculosis	Yes No Unknown	
Diabetes Mellitus	Yes No Unknown	
Other endocrine disorder	Yes No Unknown	If YES, specify:
Cardiovascular disease	Yes No Unknown	
Hypertension	Yes No Unknown	
Coronary artery disease	Yes No Unknown	
Heart failure/Congestive heart failure	Yes No Unknown	
Cerebrovascular accident/Stroke	Yes No Unknown	
Congenital heart disease	Yes No Unknown	
Other	Yes No Unknown	If YES, specify:
Renal disease	Yes No Unknown	
Chronic kidney disease/insufficiency	Yes No Unknown	
End-stage renal disease	Yes No Unknown	
Dialysis	Yes No Unknown	
Hemodialysis	Yes No Unknown	
Peritoneal dialysis	Yes No Unknown	
Other	Yes No Unknown	If YES, specify:
Liver disease	Yes No Unknown	
Alcoholic hepatitis	Yes No Unknown	
Chronic liver disease	Yes No Unknown	
Cirrhosis/End stage liver disease	Yes No Unknown	
Hepatitis B, chronic	Yes No Unknown	
Hepatitis C, chronic	Yes No Unknown	
Non-alcoholic fatty liver disease (NAFLD)/NASH	Yes No Unknown	
Other	Yes No Unknown	If YES, specify:
Immunocompromised Condition	Yes No Unknown	
HIV infection	Yes No Unknown	
AIDS or CD4 count <200	Yes No Unknown	
Solid organ transplant	Yes No Unknown	
Stem cell transplant (e.g., bone marrow transplant)	Yes No Unknown	
Cancer: current/in treatment or diagnosed in last 12 months	Yes No Unknown	
Other	Yes No Unknown	If YES, specify:
Immunosuppressive therapy	Yes No Unknown	If YES, specify: For what condition:
Neurologic/neurodevelopmental disorder	Yes No Unknown	If YES, specify:
Rheumatologic disorder	Yes No Unknown	If YES, specify:
Psychiatric diagnosis	Yes No Unknown	If YES, specify:
Blood disorder (e.g., sickle cell anemia)	Yes No Unknown	If YES, specify:
Other chronic diseases	Yes No Unknown	If YES, specify:

nCoV ID: ___________

Laboratory Specimens & SARS-CoV-2 Testing

Date of collection *(mm/dd/yyyy):*	Specimen Type	Test Type	Result	Lowest Ct value if PCR	Copy of Report Available	Sample Available
			Pos Neg		Yes No	Yes No
			Pos Neg		Yes No	Yes No
			Pos Neg		Yes No	Yes No
			Pos Neg		Yes No	Yes No
			Pos Neg		Yes No	Yes No
			Pos Neg		Yes No	Yes No
			Pos Neg		Yes No	Yes No
			Pos Neg		Yes No	Yes No
			Pos Neg		Yes No	Yes No
			Pos Neg		Yes No	Yes No
			Pos Neg		Yes No	Yes No
			Pos Neg		Yes No	Yes No