

2.6. Clinical Information	
Date of Onset of Illness (MM/DD/YYYY)* _____	Comorbidities (Check all that apply if present)
Signs and Symptoms (Check all that apply)	
<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Fever _____ °C <input type="checkbox"/> Cough <input type="checkbox"/> General weakness <input type="checkbox"/> Fatigue <input type="checkbox"/> Headache <input type="checkbox"/> Myalgia <input type="checkbox"/> Sore throat <input type="checkbox"/> Coryza	<input type="checkbox"/> Dyspnea <input type="checkbox"/> Anorexia <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Altered Mental Status <input type="checkbox"/> Anosmia (loss of smell, w/o any identified cause) <input type="checkbox"/> Ageusia (loss of taste, w/o any identified cause) <input type="checkbox"/> Others, specify _____
	<input type="checkbox"/> None <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Lung Disease <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Genito-urinary <input type="checkbox"/> Neurological Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Others _____
	Pregnant? <input type="checkbox"/> Yes, LMP (MM/DD/YYYY) _____ <input type="checkbox"/> No High-risk pregnancy? <input type="checkbox"/> Yes _____ <input type="checkbox"/> No Was diagnosed to have Severe Acute Respiratory Illness? <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest imaging findings suggestive of COVID-19	
Date done	Chest imaging done
	<input type="checkbox"/> Chest radiography <input type="checkbox"/> Chest CT <input type="checkbox"/> Lung ultrasound <input type="checkbox"/> None
Results	<input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Chest radiography: Hazy opacities, often rounded in morphology, with peripheral and lower lung dist. <input type="checkbox"/> Chest CT: Multiple bilateral ground glass opacities, often rounded in morphology, w/ peripheral & lower lung dist. <input type="checkbox"/> Lung ultrasound: Thickened pleural lines, B lines, consolidative patterns with or without air bronchograms <input type="checkbox"/> Other findings, specify _____
2.7. Laboratory Information	
Have tested positive using RT-PCR before? *	<input type="checkbox"/> Yes, date of specimen Collection (MM/DD/YYYY)* _____ <input type="checkbox"/> No Laboratory* _____ No. of previous RT-PCR swabs done _____
Date collected*	Date released
	Laboratory* BGHMC
Type of test*	Results*
<input type="checkbox"/> RT-PCR (OPS) <input type="checkbox"/> RT-PCR (NPS) <input type="checkbox"/> RT-PCR (OPS and NPS) <input type="checkbox"/> Others: _____	<input type="checkbox"/> Pending <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Equivocal <input type="checkbox"/> Others: _____
<input type="checkbox"/> Antigen; reason _____ <input type="checkbox"/> brand of kit _____ <input type="checkbox"/> Antibody Test	<input type="checkbox"/> Pending <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Equivocal <input type="checkbox"/> Others: _____
2.8. Outcome/Condition at Time of Report*	
<input type="checkbox"/> Active (currently admitted/isolation/quarantine) <input type="checkbox"/> Recovered, date of recovery (MM/DD/YYYY)* _____ <input type="checkbox"/> Died, date of death (MM/DD/YYYY)* _____	
If died, cause of death*	Immediate Cause: _____ Underlying Cause: _____
	Antecedent Cause: _____ Contributory Conditions: _____

PART 3. Contact, Tracing, Exposure and Travel History	
History of exposure to known probable and/or confirmed COVID-19 case 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection? *	<input type="checkbox"/> Yes, date of last contact (MM/DD/YYYY)* _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
Has the patient been in a place with a known COVID-19 transmission 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection? *	<input type="checkbox"/> Yes, International <input type="checkbox"/> Yes, Local <input type="checkbox"/> No <input type="checkbox"/> Unknown exposure
If International Travel, country of origin	Inclusive travel dates: _____ From: _____ To: _____ With ongoing COVID-19 community transmission? <input type="checkbox"/> Yes <input type="checkbox"/> No
Airline/Sea vessel	Flight/Vessel Number
	Date of departure (MM/DD/YYYY)
	Date of arrival in PH (MM/DD/YYYY)
If Local Travel, specify travel places (Check all that apply, provide name of facility, address, and inclusive travel dates in MM/DD/YYYY)	
Place Visited	Name of Place
	Address (Region, Province, Municipality/City)
	Inclusive Travel Dates From: _____ To: _____
	With ongoing COVID-19 Community Transmission? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Health Facility	NDCH
	CAR - BENGUET (BAGUIO CITY)
<input type="checkbox"/> Closed Settings	
<input type="checkbox"/> School	
<input type="checkbox"/> Workplace	
<input type="checkbox"/> Market	
<input type="checkbox"/> Social Gathering	
<input type="checkbox"/> Others	
<input type="checkbox"/> Transport Service, specify the following:	
Airline / Sea vessel / Bus line / Train	Flight / Vessel / Bus No.
	Place of Origin
	Departure Date (MM/DD/YYYY)
	Destination
	Date of Arrival (MM/DD/YYYY)
- If symptomatic, provide names and contact numbers of persons who were with the patient two days prior to onset of illness until this date - If asymptomatic, provide names and contact numbers of persons who were with the patient on the day specimen was submitted for testing until this date	Name (Use the back page if needed)
	Contact Number



- 1) The Case Investigation Form (CIF) is meant to be administered as an interview by a health care worker or any personnel of the DRU. This is not a self-administered questionnaire.
2) Please be advised that DRUs are only allowed to obtain 1 copy of accomplished CIF from a patient.
3) Please fill out all blanks and put a check mark on the appropriate box. Never leave an item blank (write N/A). Items with * are required fields. All dates must be in MM/DD/YYYY format.

Disease Reporting Unit*		DRU Region and Province	PhilHealth No.*
NOTRE DAME DE CHARTRES HOSPITAL		CAR - BENGUET (BAGUIO CITY)	
Name of Interviewer		Contact Number of Interviewer	Date of Interview (MM/DD/YYYY)*
Name of Informant (if applicable)		Relationship	Contact Number of Informant
If existing case (check all that apply)*	<input type="checkbox"/> Not applicable (New case)	<input type="checkbox"/> Update case classification	<input type="checkbox"/> Update disposition
	<input checked="" type="checkbox"/> Not applicable (Unknown)	<input type="checkbox"/> Update vaccination	<input type="checkbox"/> Update exposure / travel history
	<input type="checkbox"/> Update symptoms	<input type="checkbox"/> Update lab result	<input type="checkbox"/> Others, specify:
	<input type="checkbox"/> Update health status / outcome	<input type="checkbox"/> Update chest imaging findings	
Type of Client*	<input type="checkbox"/> COVID-19 Case (Suspect, Probable, or Confirmed)	<input type="checkbox"/> Close Contact	<input type="checkbox"/> For RT-PCR Testing (Not a Case of Close Contact)
Testing Category/Subgroup* (Check all that apply, refer to Appendix 2)		<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J	

Part 1. Patient Information			
1.1. Patient Profile			
Last Name*		First Name (and Suffix)*	Middle Name*
Birthday (MM/DD/YYYY)*		Age*	Sex* <input type="checkbox"/> Male <input type="checkbox"/> Female
Civil Status		Nationality*	
Occupation		Works in a closed setting? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
1.2. Current Address in the Philippines and Contact Information* (Provide address of institution if patient lives in closed settings, see 1.5)			
House No./Lot/Bldg.*	Street/Purok/Sitio*	Barangay*	Municipality/City*
Province*	Home Phone No. (& Area Code)	Cellphone No.*	Email Address
1.3. Permanent Address and Contact Information (if different from current address)			
House No./Lot/Bldg.	Street/Purok/Sitio	Barangay	Municipality/City
Province	Home Phone No. (& Area Code)	Cellphone No.	Email Address
1.4. Current Workplace Address and Contact Information			
Lot/Bldg.	Street	Barangay	Municipality/City
Province	Name of Workplace	Phone No./Cellphone No.	Email Address
1.5. Special Population (indicate further details on exposure and travel history in Part 3)			
Health Care Worker*	<input type="checkbox"/> Yes, name of health facility: _____ and location: _____		<input type="checkbox"/> No
Returning Overseas Filipino*	<input type="checkbox"/> Yes, country of origin: _____ and Passport number: _____ OFW: <input type="checkbox"/> OFW <input type="checkbox"/> Non-OFW		<input type="checkbox"/> No
Foreign National Traveler*	<input type="checkbox"/> Yes, country of origin: _____ and Passport number: _____		<input type="checkbox"/> No
Locally Stranded Individual / APOR / Local Traveler*	<input type="checkbox"/> Yes, City, Municipality, & Province of origin _____ <input type="checkbox"/> Locally Stranded Individual <input type="checkbox"/> Authorized Person Outside Residence / Local Traveler		<input type="checkbox"/> No
Lives in Closed Settings*	<input type="checkbox"/> Yes, institution type: _____ and name: _____ (e.g. prisons, residential facilities, retirement communities, care homes, camps, etc.)		<input type="checkbox"/> No

Part 2. Case Investigation Details					
2.1. Consultation Information					
Have previous COVID-19 related consultation?		<input type="checkbox"/> Yes, Date of First Consult (MM/DD/YYYY)* _____			<input type="checkbox"/> No
Name of facility where first consult was done					
2.2. Disposition at Time of Report* (Provide name of hospital/isolation/quarantine facility)					
<input type="checkbox"/> Admitted in hospital _____		Date and Time admitted in hospital _____			
<input type="checkbox"/> Admitted in isolation/quarantine facility _____		Date and Time isolated/quarantined in facility _____			
<input type="checkbox"/> In home isolation/quarantine		Date and Time isolated/quarantined at home _____			
<input type="checkbox"/> Discharged to home		If discharged: Date of Discharge (MM/DD/YYYY)* _____		<input type="checkbox"/> Others: _____	
2.3. Health Status at Consult* (Refer to Appendix 3)		<input type="checkbox"/> Asymptomatic	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe <input type="checkbox"/> Critical
2.4. Case Classification* (Refer to Appendix 1)		<input type="checkbox"/> Suspect	<input type="checkbox"/> Probable	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Non-COVID-19 Case
2.5. Vaccination information*					
Date of vaccination*	Name of Vaccine*	Dose number (e.g. 1 st , 2 nd)*	Vaccination center/facility	Region of health facility	Adverse event/s?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No