Philippine Integrated Disease Surveillance and Response

Case Investigation Form
Coronavirus Disease (COVID-19)
Version 7

General Instructions

1) The Case Investigation Form is meant to be administered as an Interview by a health care worker or any personnel of the Disease Reporting Unit. **This is not a Self-Administered Questionnaire**.
2) Please be advised that Disease Reporting Units 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, just write N/A or not applicable. **Items with * are required fields.**
4) All dates must be in **MM/DD/YYYY format.**

Disease Reporting Unit*	DRU Region and Province	PhilHealth No.*
NOTRE DAME DE CHARTRES	CAR - BENGUET	
Name of Interviewer NOTRE DAME	Contact Number of Interviewer	Date of Interview (MM/DD/YYYY) *
Name of Informant (If patient unavailable)	Relationship	Contact Number of Informant

Type of Client: ☐ COVID-19 Case (Suspect, Probable, or Confirmed) ☐ Close Contact ☐ For RT-PCR Testing (Not a Case of Close Contact) ☐ Others, please specify

1. Testing Category / Subgroup (Check all that apply) *Refer to Appendix 1*

☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ I ☐ J

Part 1. Patient Information

2. Patient Profile

Last Name*	First Name (and Suffix) *	Middle Name*
Birthday (MM/DD/YYYY) *	Age*	Sex* Male Female
Civil Status	Nationality	Occupation

3. Current Address in the Philippines and Contact Information* (Give address of institution if you live in closed settings, see Part 2 #9)

House No./Lot/Bldg.	Street/Purok/Sitio	Barangay	Municipality/City
Province	Home Phone No. (& Area Code)	Cellphone No.	Email Address

4. Current Workplace Address and Contact Information

Lot/Bldg.	Street	Barangay	Municipality/City
Province	Name of Workplace	Phone No./Cellphone No.	Email Address

5. Consultation and Admission Information

Did you have previous COVID-19 related consultation?	☐ Yes, Date of First Consult (MM/DD/YYYY)* _____ ☐ No
Name of facility where first consult was done	
Was the case admitted in a health facility?	☐ Yes, Date of Admission (MM/DD/YYYY)* *Indicate earliest date if* ☐ No *admitted in multiple health facilities* _____
Name of Facility where patient was first admitted	
Region and Province of Facility	

6. Disposition at Time of Report* (Provide name of hospital/isolation/quarantine facility)

☐ Admitted in hospital _____ Date and Time admitted in hospital _____
☐ Admitted in isolation/quarantine facility _____ Date and Time isolated/quarantined in facility _____
☐ In home isolation/quarantine Date and Time isolated/quarantined at home _____
☐ Discharged to home If Discharged: Date of Discharge (MM/DD/YYYY)* _____ ☐ Others: _____

7. Health Status at Consult*

☐ Asymptomatic ☐ Mild ☐ Moderate ☐ Severe ☐ Critical

8. Case Classification* (*Refer to Appendix 2*)

☐ Suspect ☐ Probable ☐ Confirmed ☐ Non-COVID-19 Case

PART 2: Case Investigation Details

9. Special Population

Health Care Worker*	☐ Yes, Name & location of health facility _____	☐ No
Returning Overseas Filipino*	☐ Yes, Country of origin _____	☐ No
Foreign National Traveler*	☐ Yes, Country of origin _____	☐ No
Locally Stranded Individual/APOR/Traveler*	☐ Yes, City, Mun, & Prov of origin _____	☐ No
Lives in Closed Settings*	☐ Yes, specify Type of Institution (e.g. prisons, residential facilities, retirement ☐ No communities, care homes, camps etc.) _____ and specify Name of Institution _____	

10. 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

11. Address Outside the Philippines and Contact Information (for Overseas Filipino Workers and Individuals with Residence outside PH)

House No./Lot/Bldg.	Street	Municipality/City	Province
Country	Place of Work	Employer's Name	Employer's/Office Contact No.

12. Clinical Information

Date of Onset of Illness (MM/DD/YYYY)* _____	Comorbidities (Check all that apply if present)
Signs and Symptoms (Check all that apply if present)	

☐ Asymptomatic	☐ Dyspnea	☐ None	☐ Gastrointestinal
☐ Fever _____ °C	☐ Anorexia	☐ Hypertension	☐ Genito-urinary
☐ Cough	☐ Nausea	☐ Diabetes	☐ Neurological Disease
☐ General weakness	☐ Vomiting	☐ Heart Disease	☐ Cancer
☐ Fatigue	☐ Diarrhea	☐ Lung Disease	☐ Others _____
☐ Headache	☐ Altered Mental Status	Are you pregnant?	☐ Yes, LMP _____ ☐ No
☐ Myalgia ☐ Sore throat ☐ Coryza	☐ Anosmia (loss of smell) ☐ Ageusia (loss of taste) ☐ Others _____	High-risk pregnancy?	☐ Yes ☐ No

Were you diagnosed to have Severe Acute Respiratory Illness? *(Refer to Appendix 2)* ☐ Yes ☐ No

Chest imaging findings suggestive of COVID-19

Imaging Done (Check all that apply)	Results	
☐ Chest radiography	☐ Normal ☐ Pending	Hazy opacities, often rounded in morphology, with peripheral and lower lung distribution. Other findings, specify _____
☐ Chest CT	☐ Normal ☐ Pending	Multiple bilateral ground glass opacities, often rounded in morphology, with peripheral and lower lung distribution. Other findings, specify _____
☐ Lung ultrasound	☐ Normal ☐ Pending	Thickened pleural lines, B lines (multifocal, discrete, or confluent), consolidative patterns with or without air bronchograms. Other findings, specify _____

☐ None

13. Laboratory Information

Test Done* (Check all that apply)	Date Collected*	Laboratory	Results*	Date Released
☐ RT-PCR (OPS)			☐ Pending ☐ Negative ☐ Positive ☐ Equivocal	
☐ RT-PCR (NPS)			☐ Pending ☐ Negative ☐ Positive ☐ Equivocal	
☐ RT-PCR (OPS & NPS)			☐ Pending ☐ Negative ☐ Positive ☐ Equivocal	
☐ RT-PCR (specimen type _____)			☐ Pending ☐ Negative ☐ Positive ☐ Equivocal	
☐ Antigen Test			☐ Pending ☐ Negative ☐ Positive ☐ Equivocal	
☐ Antibody Test			☐ IgM (+) IgG (-) ☐ IgM (+) IgG (+) ☐ IgG (+) IgM (-) ☐ IgM (-) IgG (-)	
☐ Others_____			Specify Result:	

Have you ever tested positive using RT-PCR before? ☐ Yes, Date of Specimen Collection (MM/DD/YYYY)* _____ ☐ No

If Yes, Laboratory _____ Number of previous RT-PCR swabs done _____

14. Outcome/Condition at Time of Report*

☐ Active (Currently admitted or in isolation/quarantine) Recovered, Date of Recovery (MM/DD/YYYY)* _____

☐ Died, Date of Death (MM/DD/YYYY)* _____

Cause of Death* Immediate Cause _____

Antecedent Cause _____ Underlying Cause _____

Part 3: Contact Tracing

15. Exposure 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?*	☐ Yes, Date of LAST Contact (MM/DD/YYYY)*_____ ☐ No ☐ Unknown
Have you been in a place with a known COVID-19 community transmission 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection?*	☐ Yes ☐ No ☐ Unknown exposure

If Yes, specify place (Check all that apply, provide details such as name of establishment, transport service, venue, location etc. and date of visit in MM/DD/YYYY)

Place Visited	Details	Date of Visit	Place Visited	Details	Date of Visit
Health Facility			Transportation		
Closed Settings (e.g. Jail)			Workplace		
Market			Local Travel		
Home			Social Gathering		
International Travel			Others		
School					

16. Travel History

History of travel/visit/work in other countries with a known COVID-19 transmission 14 days before the onset of signs and symptoms		Yes, Country of exit _____No	
Airline/Sea vessel	Flight/Vessel Number	Date of Departure (MM/DD/YYYY)	Date of Arrival in PH (MM/DD/YYYY)
History of travel/visit/work in other local place with a known COVID19 transmission 14 days before the onset of signs and symptoms		☐ Yes, Place of origin _____ ☐ No	
Airline/Sea vessel/Bus line/Train	Flight/Vessel Number/ Bus No.	Date of Departure (MM/DD/YYYY)	Date of Arrival in the Current City/Mun (MM/DD/YYYY)

List the names of persons who were with you two days prior to onset of illness until this date and their contact numbers. *If asymptomatic, list the names of persons who were with you on the day you submitted specimen for testing until this date and their contact numbers. (*Use additional space below if needed).*	Name	Contact No.