Annex G2

Philippine Integrated Disease Surveillance and Response

Case Investigation Form
Coronavirus Disease (COVID-19)

Disease Reporting Unit/Hospital:	Name of Investigator:	Date of Interview:

1. Patient Profile

Last Name	First Name	Middle Name	Birthday (mm/dd/yyyy)	Age	Sex: ( ) Male ( ) Female
Occupation	Civil Status	Nationality		Passport No.	

2. Philippine Residence

2.1. Permanent Address

House No./Lot/Bldg.	Street/Barangay	Municipality/City	Province
Region	Home Phone No.	Cellphone No.	Email address

2.2. Current Address

House No./Lot/Bldg.	Street/Barangay	Municipality/City	Province
Region	Home Phone No.	Work Phone No.	Other Email address

3. Address Outside the Philippines (for Overseas Filipino Workers and Individuals with Residence Outside the Philippines)

Employer's Name:	Occupation	Place of Work:	
House No./Bldg. Name	Street	City/Municipality	Province
Country:	Office Phone No.:	Cellphone No.:	

4. Travel History

History of travel/visit/work in other countries with a known COVID-19 transmission 14 days before the onset of your signs and symptoms: ( ) Yes ( ) No	Port (Country) of exit:		
Airline/Sea vessel:	Flight/Vessel Number:	Date of Departure (mm/dd/yyyy)	Date of Arrival in Philippines:

5. Exposure History

History of **Exposure to Known COVID-19 Case** 14 days before the onset of signs and symptoms: ( ) Yes ( ) No ( ) Unknown	If yes: Date of Contact with Known COVID-19 Case (mm/dd/yyyy):
Have you been in a **place with a known COVID-19 transmission** 14 days before the onset of signs and symptoms: ( ) Yes ( ) No ( ) Unknown	If yes: Place: ( ) Work place ( ) Health facility ( ) Social gathering ( ) Religious gathering ( ) Others: specify type: _____ Date when you have been in that place: Name of the place:

List the names of persons who were with you during this (these) occasion(s) and their contact numbers: *Use the back part of this sheet when needed*	Name	Contact number
	1.	
	2.	
	3.	

6. Clinical Information

Disposition at Time of Report ( ) Inpatient ( ) Outpatient ( ) Discharged ( ) Died ( ) Unknown	
Date of Onset of Illness (mm/dd/yyyy):	Date of Admission/Consultation (mm/dd/yyyy):
Fever _____°C ( ) Cough ( ) Sore throat ( ) Colds ( ) Shortness/difficulty of breathing	
Other signs/symptoms, specify	Is there any history of other illness? ( ) Yes ( ) No If YES, specify:
Chest X-ray done? ( ) Yes ( ) No If yes, when? _____	Are you pregnant? ( ) Yes ( ) No LMP _____ Assessed as High Risk? ( ) Yes ( ) No
CXR Results: Pneumonia ( ) Yes ( ) No ( ) Pending	Other Radiologic Findings:

7. Specimen Information

Specimen Collected	If YES, Date Collected (mm/dd/yyyy)	Date sent to RITM (mm/dd/yyyy)	Date received in RITM *(to be filled up by RITM)*	Virus Isolation Result	PCR Result
( ) Serum	____/____/____	____/____/____	____/____/____		
( ) Oropharyngeal/ Nasopharyngeal swab	____/____/____	____/____/____	____/____/____		
( ) Others	____/____/____	____/____/____	____/____/____		

8. Classification

( ) Suspect Case	( ) Probable Case	( ) Confirmed Case

9. Outcome

Date of Discharge (mm/dd/yyyy):	Condition on Discharge: ( ) Improved ( ) Recovered ( ) Transferred ( ) Absconded ( ) Died

Name of Informant: (if patient not available)	Relationship:	Phone No.

Note: Please email to your concerned PhilHealth Regional Office (PRO)