FORM A1: COVID-19 CASE INVESTIGATION FORM

A01. Date of Recording (DD/MM/YYYY):	A02. Interviewed by:
☐☐☐	

A03. Unique Case ID No. (……)	A04. Case classification. Please tick (✓) one only		A05. Current status. Please tick (✓) one only
	☐ Primary contact……1 ☐ Secondary contact…2 ☐ Imported……..…3		☐ Alive……..……1 ☐ Dead……..…2 ☐ Unknown/Lost to follow up……..…….3

A06. Respondent's name:	A07. Relationship to patient: (Please tick (✓) one only)	
	☐ Self (patient)	☐ Mother
	☐ Spouse	☐ Sibling
	☐ Father	☐ Other relative
A08. Sex of Respondent: ☐ Female……1 ☐ Male……....2	A09. Age of Respondent (in years):	
A10. Mobile contact no.:		

B. Nearest Health Centre Information of Patient's Current Residence

B01. Name of Health Centre:		B05. Type of Health Centre (Please tick (✓) one only):
B02. Location of Health Centre:		☐ BHU
B03. Geog:		☐ Hospital
B04. Dzongkhag:		☐ Regional Referral Hosp. ☐ National Referral Hosp.

C. Case's demography and current residence information

C01. Patient's Name:	C02. Age (in yrs.):	C03. Sex: (Please tick (✓) one only): ☐Female……1 ☐Male……....2	C04. Contact No.:

C05. CID/Passport No.	C06. Nationality	C07. Email address:

C08. Town/Village Name:	C09. Geog Name:	C10. Dzongkhag Name:

C11. Geo-coordinate location of household location	C12a. Latitude (dd.dddd^0 format)	C12b. Longitude (dd.dddd^0 format)

C13. Occupation of a case: Please tick(✓) one:

☐Farmer…….....1
☐Housewife/house-husband (other than farmer).....2
☐Health worker ……....3
☐Civil servant (other than health worker)..……....4
☐Corporate worker……5
☐Armed forces……...6
☐Student…….……....7
☐Child (pre-school)……..…….....8
☐Religious (monk/gomchen/nun, etc).....9
☐Construction worker…….…….....10
☐Private business (excluding construction workers),.,11
☐Others (Specify)……12

C14. Education level of case: Tick (✓) the highest level obtained

☐No schooling…….1
☐Non-formal education (NFE)……....2
☐ Primary school (<=6 grade)…….....3
☐Up to higher secondary (7 – 12 grade)…….4
☐Diploma/Degree/Masters/PhD or higher…..5
☐Monastic……..….6
☐Others (specify)……....7

C15. How many people reside in your house currently?
Number:

Children (<18 yrs.)		
Adult (≥18 yrs.)		

C16. Date of first symptom onset (in days):	C17. Date when diagnosis was confirmed (DD/MM/YY)	C18. Hospital where diagnosis was confirmed (sample collection point) ☐ JDWNRH ☐ CRRH ☐ ERRH ☐ District hospital ☐ If other, specify…….

C19. Date of first hospitalization? (DD/MM/YY)	C20. Date of first health facility visit (including traditional medicine) (DD/MM/YY)	C21. Total health facilities visited to date (number) ☐☐

D. Presenting complaints or signs of illness

D01. One or more presenting symptoms. Please tick (✓) one or more:

Signs	**Yes**	**No**	**Signs**	**Yes**	**No**
D01a. Fever/history of fever			D01k. Conjunctivitis		
D01b. Sore throat			D01l. Muscle ache		
D01c. Running nose			D01m. Joint ache		
D01d. Cough			D01n. Loss of appetite		
D01e. Shortness of breath			D01o. Nose bleed		
D01f. Chills			D01p. Fatigue		
D01g. Vomiting			D01q. Seizures		
D01h. Nausea			D01r. Altered consciousness		
D01i. Headache			D01s. Other neurological signs		
D01j. Rash			D01t Other symptoms		

E. Pre-existing condition(s)

E01. Pre-existing conditions. Please tick (✓) one or more:					
Signs	**Yes**	**No**	**Signs**	**Yes**	**No**
E01a. Pregnancy			E01j. Chronic haematological disorder		
E01b. Hypertension			D01k. Chronic kidney disease		
E01c. Cancer			D01l. Chronic neurological impairment/disease		
E01d. Diabetes			D01m. Organ/bone marrow recipient		
E01e. HIV			D01n. Other immune deficiency		
E01f. Heart disease (CVD)			D01o. Other pre-existing condition		
E01g.Asthma (requiring medication)			**If yes to D01o, please specify**		
E01h. Chronic lung disease (non-asthma)					
E01i. Chronic liver disease					

F. Main treatment given

F01	Antibiotics	1…… 2…… 3…… 4……
F02	Antiviral	1……... 2…….. 3……. 4…….
F03	Chloroquine	Please tick one only: ☐Yes……1 ☐No…….....2
F04	IV IG	Please tick one only: ☐Yes……1 ☐No…….....2

G. Patient complications

G01	ICU (Intensive care unit) admission) admission date	Date (DD/MM/YY):
G02	ICU (Intensive care unit) discharge date	Date (DD/MM/YY):
G03	Mechanical ventilation start date	Date (DD/MM/YY):
G04	Mechanical ventilation stop date	Date (DD/MM/YY):
G05	Acute respiratory distress syndrome (ARDS)	**Please tick (✓) one or more.** ☐ Yes……..1 ☐ No…….....2 ☐ Unknown…….……3
G06	If 'Yes' to G05, date of start	Date (DD/MM/YY):
G07	Acute renal failure	**Please tick (✓) one or more.** ☐ Yes……..1 ☐ No…….....2 ☐ Unknown…….……3
G08	If 'Yes' to G07, date of start	Date (DD/MM/YY):
G09	Cardiac failure	**Please tick (✓) one or more.** ☐ Yes……..1 ☐ No…….....2 ☐ Unknown…….……3
G10	If 'Yes' to G09, date of start	Date (DD/MM/YY):
G11	Consumptive coagulopathy	**Please tick (✓) one or more.** ☐ Yes……..1 ☐ No…….....2 ☐ Unknown…….……3
G12	If 'Yes' to G11, date of start	Date (DD/MM/YY):
G13	Pneumonia by chest X-ray	**Please tick (✓) one or more.** ☐ Yes……..1 ☐ No…….....2 ☐ Unknown…….……3

G14	If 'Yes' to G13, date of start	Date (DD/MM/YY):
G15	Other complications	**Please tick (✓) one or more.** ☐ Yes……..1 ☐ No…….....2 ☐ Unknown…….……3
G16	If 'Yes' to G15, specify:	
G17	If 'Yes' to G15, date of start	Date (DD/MM/YY):
G18	Hypotension requiring vasopressors	**Please tick (✓) one or more.** ☐ Yes……..1 ☐ No…….....2 ☐ Unknown…….……3
G19	Extracorporeal membrane oxygenation (EMO) required	**Please tick (✓) one or more.** ☐ Yes……..1 ☐ No…….....2 ☐ Unknown…….……3
G20	Date of discharge from hospital or demise	Date (DD/MM/YY):

H. Laboratory test results

H01	Date of sample collection	Date (DD/MM/YY):
H02	Date of receipt of molecular test results	Date (DD/MM/YY):
H03	Specimen test result for COVID-19 (RT-PCR)	Please tick (✓) one: 1. Nasal swab: ☐ Positive ☐ Negative 2. Throat swab: ☐ Positive ☐ Negative 3. Nasopharyngeal swab: ☐ Positive ☐ Negative
H04	Specimen test result for COVID-19 (Serology testing)	Please tick (✓) one or more: 1. ELISA: ☐ Positive ☐ Negative 2. IFA: ☐ Positive ☐ Negative 3. IgM: ☐ Positive ☐ Negative 4. IgG; ☐ Positive ☐ Negative 5. Neutralization Assay: ☐ Positive ☐ Negative

……The End……