

COVID-19 Vaccine Breakthrough Case Investigation Form

State health department contact name: Email address: Case-Patient Demographics					Case Identificat	ion Num	bers and Contac	ts		
Sex: Race (Select all that apply): American Indian/Alasta Native Antive Hawaiian/Other Pacific Hispanic or Latino Not Hispanic or Latino Order Not Hispanic or Latino Not Hispanic or Latino Order Or	Vaccine breakthrough REDCap ID:				CDC case identification number:				State/local case identification number:	
Sex	State healt	h department o	contact name	:			Email addres	ss:		
Sex										
Sex										
Male Female Unknown Male Female Unknown Male Female Unknown Male Female Unknown More testing Male Female Unknown More testing Male Asian Black or African American More Female Unknown More testing Mobile home Office of Mobile home Office Mobi					Case-Pat	tient Den	nographics			
Female Unknown Black or African American OR Unknown Unknown County of residence: County of residence: County of residence: County of residence: Type of residence (Select one) House Correctional facility Shetter Apartment Mobile home Other Hotel Long-term care facility Unknown COVID Laboratory Confirmation Date specimen Type: Upper respiratory sample (nasopharyngeal swab) Anasal swab, nasal wash, oropharyngeal swab) Saliva Sputum Sputum Bronchoalweal ravage fluid Picural fluid Lung tissue CT Value: CT Value: Available specimens from initial COVID-19 laboratory confirmation: (Select all that apply) SARS-CoV-2 sequencing performed: Ves No Unknown COVID-19 Vaccination Information COVID-19 Vaccination Inf	Age: Sex: Race (Select all that apply):						Ethnicity:			
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County of residence: County of residence:			1	1		can				'
House Correctional facility Shelter Apartment Mobile home Other						OR Unknow		known	/n	
House Correctional facility Shelter Apartment Mobile home Other	State of res	sidence:	Cour	nty of res	sidence: Type of residence [Sele		lect one]			
COVID Laboratory Confirmation Upper respiratory sample (nasopharyngeal swab) Saliva Sputum Bronchoalveolar lavage fluid Pleural fluid Lung tissue est type: RT-PCR or other NAAT Antigen only RP-SARS-CoV-2 sequencing performed: Indeterminate GISAID accession number: COVID-19 Vaccination Information COVID-19 V						Но				ility Shelter
COVID Laboratory Confirmation Upper respiratory sample (nasopharyngeal swab) nasal swab, nasal wash, oropharyngeal swab) Saliva Sputum Bronchoalveolar lavage fluid Pleural fluid Lung tissue est type: Test result: Positive Negative Indeterminate Negative Indeterminate RARS-CoV-2 sequencing performed: Ves No Unknown GISAID accession number: GOVID-19 Vaccination Information COVID-19 Vaccination Information COVID-19 Vaccination Information COVID-19 Vaccine lot number: It years or Other: Obate received: Vaccine manufacturer and type: Outer eceived: Vaccine lot number: Outer eceived: Outer ecei						· ·		• • • • • • • • • • • • • • • • • • • •		
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Lung tissue lest type: RT-PCR or other NAAT Antigen only REARS-COV-2 sequence data Primary respiratory specimen None SARS-COV-2 sequencing performed: Yes No Unknown COVID-19 Vaccination Information COVID-1			uid							
RT-PCR or other NAAT Antigen only RT-PCR or other NAAT Antigen only Regative Indeterminate None SARS-CoV-2 sequence data Primary respiratory specimen None COVID-19 Vaccination Information COVID-19 Vaccina						,				
Antigen only Negative Indeterminate Negative Indeterminate SARS-CoV-2 sequence data Primary respiratory specimen None SARS-CoV-2 lineage: GISAID accession number: GenBank accession number: Or Other:	Test type: Test result:			t:	CT Value: Available specime		mens from	initial COVI	D-19 laboratory	
ARRS-COV-2 sequencing performed: Yes No Unknown SARS-COV-2 lineage: GISAID accession number: GenBank accession number: COVID-19 Vaccination Information DOSE # 1 //accine manufacturer and type:	,		Positive	tive		· · · · · · · · · · · · · · · · · · ·				
SARS-CoV-2 sequencing performed: Yes No Unknown SARS-CoV-2 lineage: GISAID accession number: GenBank accession number: COVID-19 Vaccination Information DOSE # 1 Vaccine manufacturer and type: or Other: Name of facility where vaccine was received: City and state where vaccine was received: DOSE # 2 Vaccine manufacturer and type: or Other: Date received: Vaccine lot number:	Antigen o	only	1			_	·			
COVID-19 Vaccination Information COSE # 1 Vaccine manufacturer and type:			indeter	minate		1				
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Vaccine manufacturer and type:										
Vaccine manufacturer and type:					COVID-19 V	accinatio	n Information			
Vaccine manufacturer and type:	DOSF # 1									
Date received: Vaccine lot number: Name of facility where vaccine was received: Dity and state where vaccine was received: DOSE # 2 Vaccine manufacturer and type: or Other: Date received: Vaccine lot number:		nufacturer and	type:				or O	ther:		
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Vaccine manufacturer and type: or Other: Date received: Vaccine lot number:	city and sta	ate where vacci	ne was receive	ea:						
Vaccine manufacturer and type: or Other: Date received: Vaccine lot number:	DOSF#2									
Date received: Vaccine lot number:		nufacturer and	tvpe:				or O	ther:		

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City and state where vaccine was received:

Symptoms during the course of illness Yes	Clinical Illness Clinical symptoms reported from 2 days before to 2 weeks after the positive test (Select any present):					
No Unknown	Fever Chills Rigors Myalgia Headache Sore throat	Nausea or vomiting Diarrhea Fatigue Congestion or runny nose Cough Shortness of breath	Difficulty breathing New olfactory disorder New taste disorder OR No COVID-19-like symptoms			

regnancy	Autoimmune disease	Solid organ transplant
Diabetes mellitus	Immunocompromised	Hematopoietic stem cell transplant
Chronic kidney disease	HIV infection	Other immunosuppressive condition: (specify)
Chronic liver disease	Active cancer	
remic immunosunnressive ther	uny or medications (i.e. chemotherany cort	icosternids monoclonal antibodies excludes tonical ag
temic immunosuppressive thera inhaled steroids) Yes	apy or medications (i.e., chemotherapy, cort	ticosteroids, monoclonal antibodies, excludes topica
inhaled steroids)	apy or medications (i.e., chemotherapy, cort	ticosteroids, monoclonal antibodies, excludes topical ag

		Clinical Co	urse	
Presented for outpatient medical positive test:	care (e.g., tel	emedicine, clinic, urgent ca	re, or emergency room) from 2 days before to 2 weeks after the	
Yes				
No				
Unknown				
Hospitalized for ≥1 night in an inpatient facility within 2 weeks after the positive test:	If Yes	Admitted to an intensi	ve care unit during the hospitalization:	
Yes	763	Yes	To tail aim aamig the nospitalization	
No		No		
Unknown	Unknown			
Olikilowii				
		Required mechanical v	entilation during the hospitalization:	
		Yes		
		No		
		Unknown		
		Hospitalization related	I to SARS-CoV-2 infection:	
		Yes		
		No		
		Unknown		
Died:				
Yes	I			
No	If Yes	Date died:	Death related to SARS-CoV-2 infection:	
Unknown			Yes	
			No	
			Unknown	