The following document is for historical purposes and is no longer being updated. Please go to the COVID-19 website for more recent information.

nCoV ID: _____

PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC

Patient first name: _____ Patient last name: _____ Date of birth *(mm/dd/yyyy)*: _____

PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC

SARS-CoV-2 Reinfection Case Investigation Form

Reporting jurisdiction: _____ Case state/local ID: _____

Reporting health department: _____ CDC 2019-nCoV ID: _____

Hospital MRN: _____

Interviewer information

Last Name: _____ First Name: _____

Affiliation/Organization: _____

Telephone: _____ Email: _____ Date of interview *(mm/dd/yyyy)*: _____

Date of medical chart abstraction *(mm/dd/yyyy)*: _____

Data sources used for this form?

☐ Case-patient interview ☐ Other interview, specify relationship to case: _____ ☐ Medical Chart Abstraction

Case-patient's primary language: _____ Was this form administered via a translator? ◯ Yes ◯ No ◯ Unknown

Case-patient demographic information

1. Age: _____ Age units: ◯ Years ◯ Months ◯ Days
2. Sex: ◯ Male ◯ Female ◯ Other ◯ Unknown
3. Ethnicity: ◯ Hispanic/Latinx ◯ Non-Hispanic/Latinx ◯ Unknown
4. Race (check all that apply): ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ Other, specify: _____
5. County of Residence: _____ State of Residence: _____
6. Country of Residence: ◯ United States ◯ Other, specify: _____
7. Occupation: _____
8. Was this patient employed as a health care worker or first responder since Jan. 1st, 2020? ◯ Yes ◯ No ◯ Unknown
9. Was this patient a long-term care facility resident prior to initial diagnosis? ◯ Yes ◯ No ◯ Unknown
10. Was this patient employed in a laboratory that processes SARS-CoV-2 samples? ◯ Yes ◯ No ◯ Unknown
11. Has the patient visited, worked at, or resided in any of the following:
    ☐ Prison ☐ School, *specify:* ☐ Preschool ☐ K-12 ☐ College
    ☐ Meat processing plant ☐ Other congregate setting, describe: _____
    ☐ Church ☐ None
12. Did the patient come into contact with a person with known SARS-CoV-2 infection in the two weeks prior to their second illness episode?
    ◯ Yes ◯ No ◯ Unknown

First Episode

13. Date of suspected SARS-CoV-2 reinfection positive PCR test *(mm/dd/yyyy)*: _____
14. If symptomatic on 1st episode, date of symptom onset *(mm/dd/yyyy)*: _____ ◯ Asymptomatic ◯ Unknown

nCoV ID: _____

15. What were the symptoms on presentation:

Symptom	Present?	Symptom	Present?
Fever ≥100.4F (38C)	○ Yes ○ No ○ Unknown	Cough (new onset or worsening of chronic cough)	○ Yes ○ No ○ Unknown
Subjective fever (felt feverish)	○ Yes ○ No ○ Unknown	Wheezing	○ Yes ○ No ○ Unknown
Chills	○ Yes ○ No ○ Unknown	Shortness of breath (dyspnea)	○ Yes ○ No ○ Unknown
Rigors	○ Yes ○ No ○ Unknown	Difficulty breathing	○ Yes ○ No ○ Unknown
Muscle aches (myalgia)	○ Yes ○ No ○ Unknown	Chest Pain	○ Yes ○ No ○ Unknown
Runny nose (rhinorrhea)	○ Yes ○ No ○ Unknown	Nausea or vomiting	○ Yes ○ No ○ Unknown
Sore throat	○ Yes ○ No ○ Unknown	Abdominal pain	○ Yes ○ No ○ Unknown
New olfactory and taste disorder(s)	○ Yes ○ No ○ Unknown	Diarrhea (≥3 loose/looser than normal stools/24hr period)	○ Yes ○ No ○ Unknown
Headache	○ Yes ○ No ○ Unknown	Other, specify:	○ Yes ○ No ○ Unknown
Fatigue	○ Yes ○ No ○ Unknown		

16. What is the highest level of care received during this episode?
○ Self-care/Over-the-counter ○ Emergency department/urgent care ○ Intensive Care Unit
○ Outpatient/Telemedicine ○ Hospitalized ○ Received mechanical ventilation

17. If hospitalized, what was the length of stay (in days): _____ 18. If hospitalized, date of discharge *(mm/dd/yyyy)*: _____

19. Did the patient receive treatment for SARS-CoV-2? ○ Yes ○ No ○ N/A If yes, specify: _____

20. Did the patient recover (defined as afebrile without antipyretics AND progressive improvement/resolution of symptoms)? ○ Yes ○ No ○ N/A

If yes, date of recovery *(mm/dd/yyyy)*: _____

21. Comments about 1st course of illness:

_____

Second Episode

22. Date of suspected SARS-CoV-2 reinfection positive PCR test *(mm/dd/yyyy)*: _____

23. If symptomatic on 2nd episode, date of symptom onset *(mm/dd/yyyy)*: _____ ○ Asymptomatic ○ Unknown

24. What were the symptoms on presentation:

Symptom	Present?	Symptom	Present?
Fever ≥100.4F (38C)	○ Yes ○ No ○ Unknown	Cough (new onset or worsening of chronic cough)	○ Yes ○ No ○ Unknown
Subjective fever (felt feverish)	○ Yes ○ No ○ Unknown	Wheezing	○ Yes ○ No ○ Unknown
Chills	○ Yes ○ No ○ Unknown	Shortness of breath (dyspnea)	○ Yes ○ No ○ Unknown
Rigors	○ Yes ○ No ○ Unknown	Difficulty breathing	○ Yes ○ No ○ Unknown
Muscle aches (myalgia)	○ Yes ○ No ○ Unknown	Chest Pain	○ Yes ○ No ○ Unknown
Runny nose (rhinorrhea)	○ Yes ○ No ○ Unknown	Nausea or vomiting	○ Yes ○ No ○ Unknown
Sore throat	○ Yes ○ No ○ Unknown	Abdominal pain	○ Yes ○ No ○ Unknown
New olfactory and taste disorder(s)	○ Yes ○ No ○ Unknown	Diarrhea (≥3 loose/looser than normal stools/24hr period)	○ Yes ○ No ○ Unknown
Headache	○ Yes ○ No ○ Unknown	Other, specify:	○ Yes ○ No ○ Unknown
Fatigue	○ Yes ○ No ○ Unknown		

25. What is the highest level of care received during this episode?
○ Self-care/Over-the-counter ○ Emergency department/urgent care ○ Intensive Care Unit
○ Outpatient/Telemedicine ○ Hospitalized ○ Received mechanical ventilation

26. If hospitalized, what was the length of stay (in days): _____ 27. If hospitalized, date of discharge *(mm/dd/yyyy)*: _____

28. Did the patient receive treatment for SARS-CoV-2? ○ Yes ○ No ○ N/A If yes, specify: _____

29. Did the patient recover (defined as afebrile without antipyretics AND progressive improvement/resolution of symptoms)? ○ Yes ○ No ○ N/A

30. If symptoms are ongoing, what is the date of the last known symptoms for 2nd episode *(mm/dd/yyyy)*? _____

31. If symptomatic, are the recurrent symptoms better explained by a non-COVID-19 etiology? ○ Yes ○ No ○ N/A

If yes, what laboratory evidence supports an alternative etiology: _____

32. Does the treating physician suspect that this is a case of SARS-CoV-2 reinfection? ○ Yes ○ No ○ N/A

33. Comments about 2nd course of illness:

nCoV ID: _____

Past medical history

34. Does the patient have any pre-existing medical conditions? ◯ Yes ◯ No ◯ N/A

Condtion	Present?	Details
Chronic Lung Disease	◯ Yes ◯ No ◯ Unknown	
Asthma/reactive airway disease	◯ Yes ◯ No ◯ Unknown	
Emphysema/COPD	◯ Yes ◯ No ◯ Unknown	
Other chronic lung disease	◯ Yes ◯ No ◯ Unknown	If YES, specify:
Active tuberculosis	◯ Yes ◯ No ◯ Unknown	
Diabetes Mellitus	◯ Yes ◯ No ◯ Unknown	
Other endocrine disorder	◯ Yes ◯ No ◯ Unknown	If YES, specify:
Cardiovascular disease	◯ Yes ◯ No ◯ Unknown	
Hypertension	◯ Yes ◯ No ◯ Unknown	
Coronary artery disease	◯ Yes ◯ No ◯ Unknown	
Heart failure/Congestive heart failure	◯ Yes ◯ No ◯ Unknown	
Cerebrovascular accident/Stroke	◯ Yes ◯ No ◯ Unknown	
Congenital heart disease	◯ Yes ◯ No ◯ Unknown	
Other	◯ Yes ◯ No ◯ Unknown	If YES, specify:
Renal disease	◯ Yes ◯ No ◯ Unknown	
Chronic kidney disease/insufficiency	◯ Yes ◯ No ◯ Unknown	
End-stage renal disease	◯ Yes ◯ No ◯ Unknown	
Dialysis	◯ Yes ◯ No ◯ Unknown	
Hemodialysis	◯ Yes ◯ No ◯ Unknown	
Peritoneal dialysis	◯ Yes ◯ No ◯ Unknown	
Other	◯ Yes ◯ No ◯ Unknown	If YES, specify:
Liver disease	◯ Yes ◯ No ◯ Unknown	
Alcoholic hepatitis	◯ Yes ◯ No ◯ Unknown	
Chronic liver disease	◯ Yes ◯ No ◯ Unknown	
Cirrhosis/End stage liver disease	◯ Yes ◯ No ◯ Unknown	
Hepatitis B, chronic	◯ Yes ◯ No ◯ Unknown	
Hepatitis C, chronic	◯ Yes ◯ No ◯ Unknown	
Non-alcoholic fatty liver disease (NAFLD)/NASH	◯ Yes ◯ No ◯ Unknown	
Other	◯ Yes ◯ No ◯ Unknown	If YES, specify:
Immunocompromised Condition	◯ Yes ◯ No ◯ Unknown	
HIV infection	◯ Yes ◯ No ◯ Unknown	
AIDS or CD4 count <200	◯ Yes ◯ No ◯ Unknown	
Solid organ transplant	◯ Yes ◯ No ◯ Unknown	
Stem cell transplant (e.g., bone marrow transplant)	◯ Yes ◯ No ◯ Unknown	
Cancer: current/in treatment or diagnosed in last 12 months	◯ Yes ◯ No ◯ Unknown	
Other	◯ Yes ◯ No ◯ Unknown	If YES, specify:
Immunosuppressive therapy	◯ Yes ◯ No ◯ Unknown	If YES, specify: For what condition:
Neurologic/neurodevelopmental disorder	◯ Yes ◯ No ◯ Unknown	If YES, specify:
Rheumatologic disorder	◯ Yes ◯ No ◯ Unknown	If YES, specify:
Psychiatric diagnosis	◯ Yes ◯ No ◯ Unknown	If YES, specify:
Blood disorder (e.g., sickle cell anemia)	◯ Yes ◯ No ◯ Unknown	If YES, specify:
Other chronic diseases	◯ Yes ◯ No ◯ Unknown	If YES, specify:

nCoV ID: ___________

Laboratory Specimens & SARS-CoV-2 Testing

Date of collection *(mm/dd/yyyy)*:	Specimen Type	Test Type	Result	Lowest Ct value if PCR	Copy of Report Available	Sample Available
			○ Pos ○ Neg		○ Yes ○ No	○ Yes ○ No
			○ Pos ○ Neg		○ Yes ○ No	○ Yes ○ No
			○ Pos ○ Neg		○ Yes ○ No	○ Yes ○ No
			○ Pos ○ Neg		○ Yes ○ No	○ Yes ○ No
			○ Pos ○ Neg		○ Yes ○ No	○ Yes ○ No
			○ Pos ○ Neg		○ Yes ○ No	○ Yes ○ No
			○ Pos ○ Neg		○ Yes ○ No	○ Yes ○ No
			○ Pos ○ Neg		○ Yes ○ No	○ Yes ○ No
			○ Pos ○ Neg		○ Yes ○ No	○ Yes ○ No
			○ Pos ○ Neg		○ Yes ○ No	○ Yes ○ No
			○ Pos ○ Neg		○ Yes ○ No	○ Yes ○ No
			○ Pos ○ Neg		○ Yes ○ No	○ Yes ○ No