Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Evaluating and Reporting Persons Under Investigation (PUI)

Summary of Recent Changes

Revisions were made on March 4, 2020, to reflect the following:

- Criteria for evaluation of Persons Under Investigation (PUI) were expanded to a wider group of symptomatic patients.

Revisions were made on February 28, 2020, to reflect the following:

- Updated recommendations for specimen collection.

Updated March 4, 2020

Limited information is available to characterize the spectrum of clinical illness associated with coronavirus disease 20 (COVID-19). No vaccine or specific treatment for COVID-19 is available; care is supportive.

The CDC clinical criteria for a COVID-19 person under investigation (PUI) have been developed based on what is know about COVID-19 and are subject to change as additional information becomes available.

Contact your local or state health department

Healthcare providers should **immediately** notify their local or state health department in the event of a PUI for COVID-19.

Criteria to Guide Evaluation of PUI for COVID-19

As availability of diagnostic testing for COVID-19 increases, clinicians will be able to access laboratory tests for diagno COVID-19 through clinical laboratories performing tests authorized by FDA under an Emergency Use Authorization (E Clinicians will also be able to access laboratory testing through public health laboratories in their jurisdictions.

This expands testing to a wider group of symptomatic patients. Clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Decisions on w patients receive testing should be based on the local epidemiology of COVID-19, as well as the clinical course of illnes Most patients with confirmed COVID-19 have developed fever[1] and/or symptoms of acute respiratory illness (e.g., cou difficulty breathing). Clinicians are strongly encouraged to test for other causes of respiratory illness, including infecti such as influenza.

Epidemiologic factors that may help guide decisions on whether to test include: any persons, including healthcare workers[2], who have had close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom on or a history of travel from affected geographic areas[5] (see below) within 14 days of symptom onset.

International Areas with Sustained (Ongoing) Transmission

Last updated February 28, 2020

- China (Level 3 Travel Health Notice)
- Iran (Level 3 Travel Health Notice)
- Italy (Level 3 Travel Health Notice)
- Japan (Level 2 Travel Health Notice)
- South Korea (Level 3 Travel Health Notice)

Recommendations for Reporting, Testing, and Specimen Collection

Updated February 28, 2020

Clinicians should immediately implement recommended infection prevention and control practices if a patient is suspected of having COVID-19. They should also notify infection control personnel at their healthcare facility and thei state or local health department if a patient is classified as a PUI for COVID-19. State health departments that have identified a PUI or a laboratory-confirmed case should complete a PUI and Case Report form through the processes identified on CDC's Coronavirus Disease 2019 website. State and local health departments can contact CDC's Emerge Operations Center (EOC) at 770-488-7100 for assistance with obtaining, storing, and shipping appropriate specimens CDC for testing, including after hours or on weekends or holidays.

For initial diagnostic testing for SARS-CoV-2, CDC recommends collecting and testing upper respiratory tract specimen (nasopharyngeal AND oropharyngeal swabs). CDC also recommends testing lower respiratory tract specimens, if available. For patients who develop a productive cough, sputum should be collected and tested for SARS-CoV-2. The induction of sputum is not recommended. For patients for whom it is clinically indicated (e.g., those receiving invasive mechanical ventilation), a lower respiratory tract aspirate or bronchoalveolar lavage sample should be collected and tested as a lower respiratory tract specimen. Specimens should be collected as soon as possible once a PUI is identifi regardless of the time of symptom onset. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for COVID-19 and Biosafety FAQs for handling and processing specimens from suspected cases and PUIs.

Footnotes

[1]Fever may be subjective or confirmed

[2]For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID- without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potent exposed healthcare personnel. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessmen Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19).

[3]Close contact is defined as—

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact ca occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case

– or –

b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.

Additional information is available in CDC's updated Interim Infection Prevention and Control Recommendations fo Patients with Confirmed COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings.

Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the pe with COVID-19 (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to healthcare personnel exposed in healthcare settings as described in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposur a Healthcare Setting to Patients with COVID-19.

[4]Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVI patients in other countries.

[5]Affected areas are defined as geographic regions where sustained community transmission has been identified. Relevant affected areas will be defined as a country with at least a CDC Level 2 Travel Health Notice. See all COVID-19 Travel Health Notices.

Additional Resources:

- State health department after-hours contact list
- Directory of Local Health Departments
- World Health Organization (WHO) Coronavirus
- WHO guidance on clinical management of severe acute respiratory infection when COVID-19 is suspected

Page last reviewed: March 4