Philippine Integrated Disease Surveillance and Response

# Case Investigation Form
# Coronavirus Disease (COVID-19)

| Disease Reporting Unit/Hospital: **ALLEGIANT REGIONAL CARE HOSPITALS, INC.** | 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. |
|---|---|---|
| | | |

**COVID-19 Case Definitions:**

1. **Suspect case** – is a person who is presenting with any of the conditions below.
   a. All SARI cases where NO other etiology fully explains the clinical presentation.
   b. ILI cases with any one of the following:
      i. with no other etiology that fully explains the clinical presentation AND a history of travel to or residence in an area that reported local transmission of COVID-19 disease during the 14 days prior to symptom onset OR
      ii. with contact to a confirmed or probable case of COVID-19 in the two days prior to onset of illness of the probable/confirmed COVID-19 case until the time the probable/confirmed COVID-19 case became negative on repeat testing.
   c. Individuals with fever or cough or shortness of breath or other respiratory signs or symptoms fulfilling any one of the following conditions:
      i. Aged 60 years and above
      ii. With a comorbidity
      iii. Assessed as having a high-risk pregnancy
      iv. Health worker
2. **Probable case** – a suspect case who fulfills anyone of the following listed below.
   a. Suspect case whom testing for COVID-19 is inconclusive
   b. Suspect who tested positive for COVID-19 but whose test was not conducted in a national or subnational reference laboratory or officially accredited laboratory for COVID-19 confirmatory testing
3. **Confirmed case** – any individual, irrespective of presence or absence of clinical signs and symptoms, who was laboratory confirmed for COVID-19 in a test conducted at the national reference laboratory, a subnational reference laboratory, and/or DOH-certified laboratory testing facility.

ARC Hospitals
Sitio Malinao, Brgy. Agus, Lapu Lapu City, Cebu, Philippines 6015
Trunkline: (032) 517-6051 loc. 000 Fax: (032) 000-0000
www.archospitals.org

# PATIENT CONSENT AND AUTHORIZATION FOR RELEASE OF INFORMATION VIA EMAIL OR THROUGH REPRESENTATIVE

You have agreed to provide ARC Hospitals with your email address and / or authorized a representative to receive physical copies of your medical results. Please be aware that there are some limits on what and when we can email you and / or release through your representative.

**Please note: We do not receive emails from patients.**

Please tell us which email address you wish us to use. Don't forget to notify us of any changes to your email address.
_____ (email address)

- If you intend to receive our emails, please be sure to update your address book and check you junk/spam folder.
- Please be aware there are privacy risks in using email:
  - Email is not secure. While we try to protect our emails we cannot guarantee the security and confidentiality of any email you receive from us. As the email is sent across the Internet it could be intercepted and read.
  - Email is easy to forge, easy to forward to other people and may exist forever.
  - If you use a work email, your employer may have a right to inspect and archive emails sent from their systems. We recommend you avoid using a work email.

Please indicate below the name of your authorized representative. He / She should be able to provide an official identification card upon request of our staff.

_____ (Name of Representative)

Please indicate below the name of your company that you would like the results to be sent to. This is only applicable for patients whose company is shouldering the expenses of the RT-PCR test. Should the company request results of the patient, we will only release if the company name is written on this form.

_____ (Name of HMO or Company)

## Patient Acknowledgment, Agreement and Release of Liability

I have read and fully understand this consent and release form. I understand the risks involved with using email, my representative and I accept those risks. I agree that ARC Hospitals shall not be responsible for any personal injury including death, and/or privacy breach (outside the control of ARCH) or other damages as a result of my choice to receive emails from ARC Hospitals and I release ARC Hospitals from any liability from data privacy law breach and its legal implications relating to communicating with me by email.

SIGNATURE OVER PRINTED NAME OF PATIENT/SUBSTITUTE DECISION-MAKER:

_____

DATE: _____
CELLPHONE NUMBER: _____

DEPARTMENT OF HEALTH
**RESEARCH INSTITUTE FOR TROPICAL MEDICINE**
Alabang, Muntinlupa City, Metro Manila
(02) 8072628 to 32
www.ritm.gov.ph

**Hospital No.:** _____ **LABORATORY TEST REQUEST FORM** **Accession No.:** _____

**I. PATIENT INFORMATION:** (To be filled-out by requisitioner)

| | | |
|---|---|---|
| **Name:** (First, Middle, Last) | **Date of Birth:** (MM/DD/YYYY) | |
| **Address:** (Street, Barangay. District, Municipality, Province, Region) | **Gender:** ☐ M ☐ F | **Age:**(YY.MM) |
| **Location/ Classification:** ☐ OPD ☐ Referral ☐ AS ☐ RITM INPATIENT _____ | **Date of Admission:** (MM/DD/YYYY) | |
| **Clinical Impression:** / **Suspected Agent:** | **Date of Onset of Illness:** (MM/DD/YYYY) | |

**II. REQUISITIONER INFORMATION:** (To be filled-out by requisitioner)

| | | | | | |
|---|---|---|---|---|---|
| **Requisitioner (MD)/Disease Surveillance Officer (DSO) Name:** | | **Address:** | | | **Requisitioner MD/DSO/DRU Contact Details:** (at least 1) **Tel No.:** _____ **Fax No.:**_____ **Cell No.:** _____ **Email Address:** _____ |
| **Name of Disease Reporting Unit (DRU):** | **Type of DRU:** | **Region:** | **Province:** | **Municipality:** | |

**III. HOSPITAL INFORMATION:** (To be filled-up by RITM staff)

| | | |
|---|---|---|
| **Date and Time of Specimen Receipt:** (MM/DD/YYYY- HR:MIN) | **Received by:** printed name & signature | **Official Receipt No.** |

**IV. SPECIMEN INFORMATION AND LABORATORY TESTS:** (To be filled-out by requisitioner. Please mark with an "X" the box of the requested examination with additional information as requested. For pre-collected specimens, requisitioner to indicate the date and time of sample collection at the space provided.)

| | **SPECIMEN TYPE** | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **LABORATORY EXAMINATION** | NPS and/or OPS in VTM (specify if NPS and/or OPS) | NPS in APTM | Sputum | Serum | Respiratory specimen (specify type) | Fixed tissue (specify type, site & surgical procedure) | Blood in BHI | Others (specify type) |
| Influenza A H5N1 PCR | | | | | | | | |
| Influenza A H7N9 PCR | | | | | | | | |
| MERS Coronavirus PCR | | | | | | | | |
| *pan*Coronavirus PCR | | | | | | | | |
| Influenza A PCR and subtyping *for H1N1, H3N2 and H1N1 pdm09* | | | | | | | | |
| Influenza B PCR | | | | | | | | |
| RSV PCR | | | | | | | | |
| Aerobic Culture and Sensitivity | | | | | | | | |
| Atypical pneumonia PCR *Legionella, Mycoplasma and Chlamydophila* | | | | | | | | |
| Invasive Bacterial Diseases PCR *S. pneumo, H. influ and N. meningitides* | | | | | | | | |
| Electron Microscopy | | | | | | | | |
| Histopathological Examination | | | | | | | | |
| Others: (Refer to RITM Lab Menu) | | | | | | | | |
| Date and Time Collected: | | | | | | | | |
| Collected by: | | | | | | | | |
| **RITM Staff Only** | | | | | | | | |
| Specimen Acceptable? | ☐ YES ☐ NO _____ | ☐ YES ☐ NO _____ | ☐ YES ☐ NO _____ | ☐ YES ☐ NO _____ | ☐ YES ☐ NO _____ | ☐ YES ☐ NO _____ | ☐ YES ☐ NO _____ | ☐ YES ☐ NO _____ |

DEPARTMENT OF HEALTH
**RESEARCH INSTITUTE FOR TROPICAL MEDICINE**
Alabang, Muntinlupa City, Metro Manila
(02) 8072628 to 32
www.ritm.gov.ph

# IMPORTANT INSTRUCTIONS ON FILLING OUT THE LABORATORY TEST REQUEST FORM

The highlighted fields in the sample Laboratory Test Request Form below are the **MINIMUM REQUIRED INFORMATION** to be filled out. Failure to provide these minimum required information may result in specimen rejection and delay in specimen processing.

DEPARTMENT OF HEALTH
RESEARCH INSTITUTE FOR TROPICAL MEDICINE
Alabang, Muntinlupa City, Metro Manila
(02) 8072628 to 32
www.ritm.gov.ph

Hospital No.: | LABORATORY TEST REQUEST FORM | Accession No.:

**I. PATIENT INFORMATION:** (To be filled-up by requisitioner)

Name: (First, Middle, Last): MA. CARMEN REYES, MANALO
Date of Birth: (MM/DD/YYYY): 07 03 1973
Address: (Street, Barangay, District, Municipality, Province, Region): 21 RIZAL EXTENSION, BIÑAN, LAGUNA, REGION IVA
Gender: ☐ M ☒ F
Age: (YY.MM): 39.00
Location/ Classification: ☐ OPD ☒ Referral ☐ AS ☐ RITM INPATIENT
Date of Admission: (MM/DD/YYYY): 06 19 2013
Clinical Impression: ACUTE BRONCHITIS
Suspected Agent: MERS-CoV
Date of Onset of Illness: (MM/DD/YYYY): 06 16 2013

**II. REQUISITIONER INFORMATION:** (To be filled-up by requisitioner)

Requisitioner (MD)/Disease Surveillance Officer (DSO) Name: CARMEN MANABAT, MD
Address: BIÑAN DOCTORS HOSPITAL, PLATERO, BIÑAN, LAGUNA 4024
Requisitioner MD/DSO/DRU Contact Details: (at least 1)
Tel No.: 0494110070
Fax No.:
Cell No.: 09224563316
Email Address:

| Name of Disease Reporting Unit (DRU): | Type of DRU: | Region: | Province: | Municipality: |
|---|---|---|---|---|
| BIÑAN DOCTORS HOSPITAL | PRIVATE | IVA | LAGUNA | BIÑAN |

**III. HOSPITAL INFORMATION:** (To be filled-up by RITM staff)

| Date and Time of Specimen Receipt: (MM/DD/YYYY- HR:MIN) | Received by: printed name & signature | Official Receipt No. |
|---|---|---|
| | | |

**IV. SPECIMEN INFORMATION AND LABORATORY TESTS:** (To be filled-up by requisitioner. Please mark with an "X" the box of the requested examination with additional information as requested. For pre-collected specimens, requisitioner to indicate the date and time of sample collection at the space provided.)

| LABORATORY EXAMINATION | SPECIMEN TYPE: NPS and/or OPS in VTM (specify if NPS and/or OPS) | NPS in APTM | Sputum | Serum | Respiratory specimen (specify type) | Fixed tissue (specify type, site & surgical procedure) | Blood in BHI | Others (specify type) |
|---|---|---|---|---|---|---|---|---|
| Influenza A H5N1 PCR | | | | | | | | |
| Influenza A H7N9 PCR | | | | | | | | |
| MERS Coronavirus PCR | x NPS+OPS | | x | | x BAL | | | |
| *pan*Coronavirus PCR | | | | | | | | |
| Influenza A PCR and subtyping *for H1N1, H3N2 and H1N1 pdm09* | | | | | | | | |
| Influenza B PCR | | | | | | | | |
| RSV PCR | | | | | | | | |
| Aerobic Culture and Sensitivity | | | | | | | x | |
| Atypical pneumonia PCR *Legionella, Mycoplasma and Chlamydophila* | | x | | | | | | |
| Invasive Bacterial Diseases PCR *S. pneumo, H. influ and N. meningitides* | | | | | | | | |
| Electron Microscopy | | | | | | x PLEURAL BIOPSY | | |
| Histopathological Examination | | | | | | | | |
| Others: (Refer to RITM Lab Menu) | | | | | | | | |
| Date and Time Collected: | 06/20/2013 1920 | 06/20/2013 1930 | 06/20/2013 1930 | | 06/21/2013 0900 | 06/21/2013 0916 | 06/20/2013 1915 | |
| Collected by: | J.R.CLUZMAN | J.R.CLUZMAN | J.R.CLUZMAN | | C.MANABAT | C.MANABAT | J.R.CLUZMAN | |
| **RITM Staff Only** | | | | | | | | |
| Specimen Acceptable? | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |

Information to be filled out by RITM Staff. Please leave these fields blank.

At least one contact information required for specimen to be considered as acceptable at RITM.

Information in this section to be filled out by RITM Staff. Please leave these fields blank.

Fill out the specimen types matrix as shown in this sample form. Mark with "X" for collected specimens and the requested information; leave blank if no specimen was collected.

Specify if NPS only, OPS only or a combination of NPS and OPS.

Specify site and procedure for fixed tissues.

Indicate date and time of collection and name of staff collecting the specimen.