##### The First Few X (FFX): Cases and contact investigation protocol for 2019-nCoV

#### 2- For close contacts

*Form B1: Contact initial reporting form – for close contacts (Day 1)*

##### Confirmed Case ID / Cluster Number (if applicable):

**Contact ID Number (C…):**

Note: Contact ID numbers should be issued at the time of completion of Form A1.

##### Name of confirmed case

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| **1. Data Collector Information** | |
| Name of data collector |  |
| Data collector Institution |  |
| Phone number |  |
| Email |  |
| Form completion date (dd/mm/yyyy) | / / |

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| **2. Interview respondent information (if the persons providing the information is not the contact)** | |
| First name |  |
| Surname |  |
| Sex | □ Male □ Female □ Not known |
| Date of Birth | / / |
| Relationship to patient |  |
| Respondent address |  |
| Telephone (mobile) number |  |

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| **3. Contact Details (Details of the contact)** | |
| Given name(s) |  |
| Family name |  |
| Sex | □ Male □ Female □ Not known |
| Date of Birth | / / |
| Relationship to case |  |
| Address (village/town, district, province/region) |  |
| Telephone number |  |
| Email address |  |
| Preferred mode of contact | □ Mobile □ Work □ Home □ Email |
| Nationality |  |
| Country of residence |  |
| National social number/ identifier (optional) |  |
| Have you travelled within the last 14 days domestically? | □ Yes □ No □ Unknown |

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|  | If Yes, dates of travel (DD/MM/YYYY):  / / to / /  Regions: Cities visited: |
| Have you travelled within the last 14 days internationally? | □ Yes □ No □ Unknown  If Yes, dates of travel (DD/MM/YYYY):  / / to / /  Countries visited: Cities visited: |
| In the past 14 days, have you had contact with a anyone with suspected or confirmed 2019-nCoV infection? | □ Yes □ No □ Unknown  If Yes, dates of last contact (DD/MM/YYYY):  / / |
| Occupation (specify location/facility) | * Health care worker * Working with animals □ Health laboratory worker * Student * Other, specify:   For each occupation, please specify location or  facility: |

**Note for next 2 sections:**

* **Complete Section 4** if the contact is a Health Care Worker (HCW)**.**
* **Complete Section 5** if the contact is**.** NOT a Health Care Worker (HCW)

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| **4 Exposure Information (if the close contact is a Health Care Worker)** | |
| Job title (specify) |  |
| Place of work |  |
| Direct physical contact with the confirmed case (e.g. hands-on physical contact) | □ Yes □ No |
| Has the HCW had prolonged face-to-face contact (>15 minutes) with a symptomatic confirmed case in an health facility? | * Yes * No |
|  | If yes, what type of protective equipment was used by  the health care worker?   * Gown * Surgical/medical mask * Gloves * NIOSH-CERTIFIED N95, AN EU STANDARD FFP2 * FFP3 * Eye protection |
| Has the HCW had prolonged face-to-face contact (>15 minutes) with an asymptomatic confirmed case in a health facility? | * Yes * No |
|  | If yes, What type of protective equipment was used by  the health care worker? |

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|  | * Gown * Surgical/medical mask * Gloves * NIOSH-CERTIFIED N95, AN EU STANDARD FFP2 * FFP3 * Eye protection |
| Was the contact present while any aerosol generating procedures took place? | * Yes * No   If yes, specify procedure and date Procedure: / /  Procedure: / /  Was the contact wearing any type of a mask at this/these procedures?   * Surgical/medical * NIOSH-CERTIFIED N95, AN EU STANDARD FFP2 * FFP3 * None |

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| **5. Exposure** Information **(if the close contact is NOT a HealthCare Worker)** | | |
| Type of contact | * Household * Other, specify: | |
| State dates of contact and duration | Date | / / (dd/mm/yyyy) |
| of contact with the confirmed case |  |  |
| from first contact, while the  primary case was **symptomatic** |  |  |
| Duration | (mins) |
| (Add as many dates, as required) | Setting | * Home/ household * Hospital / health care |
|  |  | □ Workplace |
|  |  | * Tour group * Other, specify: |
| State dates of contact and duration | Date | / / (dd/mm/yyyy) |
| of contact with the confirmed case |  |  |
| from first contact, while the  primary case was **asymptomatic** |  |  |
| Duration | (mins) |
| (Add as many dates, as required) | Setting | * Home/ household * Hospital / health care |
|  |  | □ Workplace |
|  |  | * Tour group * Other, specify: |

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| **6a. Symptoms in contact** | |
| Has the contact experienced any respiratory symptoms (sore throat, cough, running nose, shortness of breath) in the period from 10 days before onset in the  confirmed case until the present? | * Yes * No |
| Has the contact experienced any respiratory symptoms (sore throat, cough, running nose, shortness of breath) in the period up to 10 days after last contact or until the  present date, whichever is the earliest? | * Yes * No |
| Currently ill | □ Yes □ No |
| Date and time of first symptom onset | / /  □ AM □ PM |
| Maximum temperature | °C □ NA |
| **6b. Respiratory symptoms** | |
| Sore throat | □ Yes □ No □ Unknown  If yes, date / / |
| Cough | □ Yes □ No □ Unknown  If yes, date / / |
| Runny nose | □ Yes □ No □ Unknown |
| Shortness of breath | □ Yes □ No □ Unknown  If yes, date / / |
| **6c. other symptoms** | |
| Chills | □ Yes □ No □ Unknown |
| Vomiting | □ Yes □ No □ Unknown |
| Nausea | □ Yes □ No □ Unknown |
| Diarrhea | □ Yes □ No □ Unknown |
| Headache | □ Yes □ No □ Unknown |
| Rash | □ Yes □ No □ Unknown |
| Conjunctivitis | □ Yes □ No □ Unknown |
| Muscle aches | □ Yes □ No □ Unknown |
| Joint ache | □ Yes □ No □ Unknown |
| Loss of appetite | □ Yes □ No □ Unknown |
| Nose bleed | □ Yes □ No □ Unknown |
| Fatigue | □ Yes □ No □ Unknown |
| Seizures | □ Yes □ No □ Unknown |
| Altered consciousness | □ Yes □ No □ Unknown |
| Other neurological signs | □ Yes □ No □ Unknown  If Yes, specify: |
| Other symptoms | □ Yes □ No □ Unknown  If yes, specify: |

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| **7. Outcome/status of contact (Only complete if contact has been ill or is currently ill)** | |
| Status | * Recovered, if yes specify date symptoms resolved   / /   * Still ill * Dead, if yes specify date of death   / /   * Unknown/ Lost to follow-up |

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| Hospitalization ever required? | □ Yes □ No □ Not Unknown  If yes, date of hospitalization and date of discharge (dd/mm/yyyy) / / - / / |
| **(NB. If the information below is not currently available, please leave blank and send through an update as soon as results are available)** | |
| If dead, contribution of 2019-nCoV to death: | * Underlying/primary * Contributing/secondary * No contribution to death * Unknown |
| If dead, was a port-mortem performed? | □ Yes □ No □ Unknown |
| If dead, cause of death on Death certificate (specify) |  |
| If dead, results of post-mortem’s report where  available: |  |

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| **8. Contact pre-existing condition(s)** | |
| Pregnancy | * Yes □ No □ Unknown   If yes, specify trimester:   * First □ Second □ Third □ NA |
| Obesity | □ Yes □ No □ Unknown |
| Heart disease | □ Yes □ No □ Unknown |
| Asthma requiring medication | □ Yes □ No □ Unknown |
| Chronic lung disease (non-asthma) | □ Yes □ No □ Unknown |
| Chronic liver disease | □ Yes □ No □ Unknown |
| Chronic haematological disorder | □ Yes □ No □ Unknown |
| Chronic kidney disease | □ Yes □ No □ Unknown |
| Chronic neurological impairment/disease | □ Yes □ No □ Unknown |
| Organ or bone marrow recipient | □ Yes □ No □ Unknown |
| Other pre-existing condition(s) | □ Yes □ No □ Unknown  If yes, specify: |
| Comments if appropriate |  |

Form B1: Contact initial reporting form – for close contacts (Day 1)

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| **9a. Virology testing methods and results:** | | | | | | | |
| **Complete a new line for each specimen collected and each type of test done:** | | | | | | | |
| **Lab identification number** | **Date Sample collected (dd/mm/yyyy)** | **Date Sample Received (dd/mm/yyyy)** | **Type of Sample** | **Type of test** | **Result** | **Result Date (dd/mm/yyyy)** | **Specimens shipped to other laboratory for confirmation** |
|  | / / | / / | * Nasal swab * Throat swab □ Nasopharyngeal swab * Others, specify: | * PCR * Whole genome   sequencing   * Partial genome   sequencing   * Other, specify | * POSITIVE for 2019-nCoV * NEGATIVE for 2019- nCoV * POSITIVE for others   pathogens  Please specify which  pathogens: …. | / / | * Yes   If yes, specify Date  / / If yes, name of the laboratory:   * No |
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| **9b. Serology testing methods and results:** | | | | | | | |
| **Complete a new line for each specimen collected and each type of test done:** | | | | | | | |
| **Lab identification number** | **Date Sample collected (dd/mm/yyyy)** | **Date Sample Received (dd/mm/yyyy)** | **Type of Sample** | **Type of test** | **Result** (2019-nCoV antibody titres) | **Result date (dd/mm/yyyy)** | **Specimens shipped to other laboratory for confirmation** |
|  |  |  | □ Serum | Specify type (ELISA / | □ POSITIVE |  | □ Yes |
| / / | / / | □ Others,  specify: | IFA IgM/ IgG,  Neutralization assay, etc): | If positive, titre : | / / | If yes, specify Date  / / |
|  |  |  |  | □ NEGATIVE |  | If yes, name of the |
|  |  |  |  | □ INCONCLUSIVE |  | laboratory: |
|  |  |  |  |  |  | □ No |
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| **10. Status of form completion** | |
| Form completed | * Yes □ No or partially   If no or partially, reason :   * Missed □ Not attempted □ Not performed * Refusal □ Other, specific: |