HI-PRECISION diagnostics | Hi-Precision Diagnostics PLUS

For your convenience, you may fill out the **Case Investigation Form** online.

Please scan or tap on the QR code below to access our form:

SCAN ME!

A reference number will be generated once you have accomplished the form.

Please take a screenshot of it and present it to our staff on the day of visit.

Thank you very much for your understanding and cooperation.

Philippine Integrated Disease Surveillance and Response

Case Investigation Form
Coronavirus Disease (COVID-19)
Version 9

1) The Case Investigation Form (CIF) is meant to be administered as an interview by a health care worker or any personnel of the DRU. **This is not a self-administered questionnaire**.
2) Please be advised that DRUs are only allowed to obtain **1 copy of accomplished CIF** from a patient.
3) Please fill out all blanks and put a check mark on the appropriate box. Never leave an item blank (write N/A). **Items with * are required fields**. All dates must be in **MM/DD/YYYY format**.

Disease Reporting Unit*	DRU Region and Province	PhilHealth No.*
Name of Interviewer	**Contact Number of Interviewer**	**Date of Interview *(MM/DD/YYYY)****
Name of Informant *(if applicable)*	**Relationship**	**Contact Number of Informant**

If existing case (*check all that apply*)*	☐ Not applicable (New case)	☐ Update case classification	☐ Update disposition
	☐ Not applicable (Unknown)	☐ Update vaccination	☐ Update exposure / travel history
	☐ Update symptoms	☐ Update lab result	☐ Others, specify:
	☐ Update health status / outcome	☐ Update chest imaging findings	_____
Type of Client*	☐ COVID-19 Case (Suspect, Probable, or Confirmed)	☐ Close Contact	☐ For RT-PCR Testing (Not a Case of Close Contact)
Testing Category/Subgroup* *(Check all that apply, refer to Appendix 2)*	☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ I ☐ J		

Part 1. Patient Information

1.1. Patient Profile

Last Name*	First Name (and Suffix)*	Middle Name*	
Birthday (MM/DD/YYYY)*	Age*	Sex* ☐ Male	☐ Female
Civil Status	Nationality*		
Occupation	Works in a closed setting? ☐ Yes	☐ No	☐ Unknown

1.2. Current Address in the Philippines and Contact Information* *(Provide address of institution if patient lives in closed settings, see 1.5)*

House No./Lot/Bldg.*	Street/Purok/Sitio*	Barangay*	Municipality/City*
Province*	**Home Phone No. (& Area Code)**	**Cellphone No.***	**Email Address**

1.3. Permanent Address and Contact Information *(if different from current address)*

House No./Lot/Bldg.	Street/Purok/Sitio	Barangay	Municipality/City
Province	**Home Phone No. (& Area Code)**	**Cellphone No.**	**Email Address**

1.4. Current Workplace Address and Contact Information

Lot/Bldg.	Street	Barangay	Municipality/City
Province	**Name of Workplace**	**Phone No./Cellphone No.**	**Email Address**

1.5. Special Population *(indicate further details on exposure and travel history in Part 3)*

Health Care Worker*	☐ Yes, name of health facility:_____ and location: _____	☐ No
Returning Overseas Filipino*	☐ Yes, country of origin: _____ and Passport number: _____ OFW: ☐ OFW ☐ Non-OFW	☐ No
Foreign National Traveler*	☐ Yes, country of origin: _____ and Passport number: _____	☐ No
Locally Stranded Individual / APOR / Local Traveler*	☐ Yes, City, Municipality, & Province of origin _____ ☐ Locally Stranded Individual ☐ Authorized Person Outside Residence / Local Traveler	☐ No
Lives in Closed Settings*	☐ Yes, institution type: _____ and name: _____ *(e.g. prisons, residential facilities, retirement communities, care homes, camps, etc.)*	☐ No

Part 2. Case Investigation Details

2.1. Consultation Information

Have previous COVID-19 related consultation?	☐ Yes, Date of First Consult *(MM/DD/YYYY)** _____	☐ No
Name of facility where first consult was done		

2.2. Disposition at Time of Report* (Provide name of hospital/isolation/quarantine facility)

☐ Admitted in hospital _____	Date and Time admitted in hospital _____
☐ Admitted in isolation/quarantine facility _____	Date and Time isolated/quarantined in facility _____
☐ In home isolation/quarantine	Date and Time isolated/quarantined at home _____
☐ Discharged to home	If discharged: Date of Discharge *(MM/DD/YYYY)** _____ ☐ Others: _____

2.3. Health Status at Consult* (*Refer to Appendix 3*)	☐ Asymptomatic	☐ Mild	☐ Moderate	☐ Severe	☐ Critical
2.4. Case Classification* (*Refer to Appendix 1*)	☐ Suspect	☐ Probable	☐ Confirmed	☐ Non-COVID-19 Case	

2.5. Vaccination information*

Date of vaccination*	Name of Vaccine*	Dose number (e.g. 1st, 2nd)*	Vaccination center/facility	Region of health facility	Adverse event/s?
					☐ Yes ☐ No
					☐ Yes ☐ No

Clear All Fields

2.6. Clinical Information

Date of Onset of Illness *(MM/DD/YYYY)** _____

Signs and Symptoms *(Check all that apply)*

☐ Asymptomatic	☐ Dyspnea
☐ Fever _____ °C	☐ Anorexia
☐ Cough	☐ Nausea
☐ General weakness	☐ Vomiting
☐ Fatigue	☐ Diarrhea
☐ Headache	☐ Altered Mental Status
☐ Myalgia	☐ Anosmia (loss of smell, w/o any identified cause)
☐ Sore throat	☐ Ageusia (loss of taste, w/o any identified cause)
☐ Coryza	☐ Others, specify_____

Comorbidities *(Check all that apply if present)*

☐ None	☐ Gastrointestinal
☐ Hypertension	☐ Genito-urinary
☐ Diabetes	☐ Neurological Disease
☐ Heart Disease	☐ Cancer
☐ Lung Disease	☐ Others _____

Pregnant?	☐ Yes, LMP *(MM/DD/YYYY)* _____	☐ No
High-risk pregnancy?	☐ Yes	☐ No
Was diagnosed to have Severe Acute Respiratory Illness?	☐ Yes	☐ No

Chest imaging findings suggestive of COVID-19

Date done	Chest imaging done	Results
	☐ Chest radiography ☐ Chest CT ☐ Lung ultrasound ☐ None	☐ Normal ☐ Pending

☐ Chest radiography: Hazy opacities, often rounded in morphology, with peripheral and lower lung dist.
☐ Chest CT: Multiple bilateral ground glass opacities, often rounded in morphology, w/ peripheral & lower lung dist.
☐ Lung ultrasound: Thickened pleural lines, B lines, consolidative patterns with or without air bronchograms
☐ Other findings, specify _____

2.7. Laboratory Information

Have tested positive using RT-PCR before? * ☐ Yes, date of specimen Collection *(MM/DD/YYYY)** _____ ☐ No

Laboratory* _____ No. of previous RT-PCR swabs done ____

Date collected*	Date released	Laboratory*	Type of test*	Results*
			☐ RT-PCR (OPS) ☐ Antigen; reason_____ ☐ RT-PCR (NPS) brand of kit _____ ☐ RT-PCR (OPS and NPS) ☐ Antibody Test ☐ Others: _____	☐ Pending ☐ Negative ☐ Positive ☐ Equivocal ☐ Others:
			☐ RT-PCR (OPS) ☐ Antigen; reason_____ ☐ RT-PCR (NPS) brand of kit _____ ☐ RT-PCR (OPS and NPS) ☐ Antibody Test ☐ Others: _____	☐ Pending ☐ Negative ☐ Positive ☐ Equivocal ☐ Others:

2.8. Outcome/Condition at Time of Report*

☐ Active (currently admitted/isolation/quarantine) ☐ Recovered, date of recovery *(MM/DD/YYYY)** _____ ☐ Died, date of death *(MM/DD/YYYY)** _____

If died, cause of death*	Immediate Cause:	Antecedent Cause:
	Underlying Cause:	Contributory Conditions:

PART 3. Contact Tracing: Exposure and Travel History

History of exposure to known probable and/or confirmed COVID-19 case 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection? * ☐ Yes, date of last contact *(MM/DD/YYYY)** _____ ☐ No ☐ Unknown

Has the patient been in a place with a known COVID-19 transmission 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection? * ☐ Yes, International ☐ Yes, Local ☐ No ☐ Unknown exposure

If International Travel, country of origin		Inclusive travel dates:	From: To:
		With ongoing COVID-19 community transmission?	☐ Yes ☐ No

Airline/Sea vessel	Flight/Vessel Number	Date of departure *(MM/DD/YYYY)*	Date of arrival in PH *(MM/DD/YYYY)*

If Local Travel, specify travel places *(Check all that apply, provide name of facility, address, and inclusive travel dates in MM/DD/YYYY)*

Place Visited	Name of Place	Address *(Region, Province, Municipality/City)*	Inclusive Travel Dates From:	Inclusive Travel Dates To:	With ongoing COVID-19 Community Transmission?
☐ Health Facility					☐ Yes ☐ No
☐ Closed Settings					☐ Yes ☐ No
☐ School					☐ Yes ☐ No
☐ Workplace					☐ Yes ☐ No
☐ Market					☐ Yes ☐ No
☐ Social Gathering					☐ Yes ☐ No
☐ Others					☐ Yes ☐ No

☐ Transport Service, specify the following:

Airline / Sea vessel / Bus line / Train	Flight / Vessel / Bus No.	Place of Origin	Departure Date *(MM/DD/YYYY)*	Destination	Date of Arrival *(MM/DD/YYYY)*

	Name (*Use the back page if needed*)	Contact Number
- If symptomatic, provide names and contact numbers of persons who were with the patient two days prior to onset of illness until this date - If asymptomatic, provide names and contact numbers of persons who were with the patient on the day specimen was submitted for testing until this date		

Clear All Fields