COVID -19 Case Investigation Form

Ministry of Health and Social Services, Namibia,
Contact information: Tel: (+264) 61 203 2211/2630/2631 | Hotline: 0800100100

Laboratory Number
EPID Number: COUNTRY-RGN-DIS-YR-SEQ NO

REASONS FOR COVID-19 TESTING

URGENT/PRIORITY

☐ HOSPITALIZED PATIENT (SYMPTOMATIC) ☐ HEALTH WORKER (SYMPTOMATIC) ☐ TRAVEL (MEDICAL REASONS)
☐ TRUCK DRIVER (CROSS BORDER) ☐ HOSPITAL ADMISSION / PRE-OP ☐ DECEASED

ROUTINE

☐ SUSPECTED NEW CASE ☐ CONTACT ☐ ACTIVE CASE SEARCH ☐ EXPANDED TARGET
☐ TESTING ☐ TRAVEL (NON-MEDICAL) ☐ CONFIRMATORY PCR TEST ☐ SUSPECTED

SPECIMEN TYPE

☐ Nasopharyngeal swab ☐ Sputum ☐ Oropharyngeal Swab ☐ Saliva ☐ other (specify):________________

TEST

☐ **PCR** ☐ **Antigen RDT** ☐ **Multiplex PCR**

Specimen Collection Date		Date received at Laboratory		Date of last positive result if suspected reinfection	

Laboratory results Positive ☐ Negative ☐ Indeterminate ☐ **Invalid (Repeat test)** ☐ Rejected ☐ Reason for rejection________________
Date of result: ____/____/____

PATIENT DETAILS

Full Name:		ID/Passport #	
DOB (yyyy/mm/dd)	Age	Sex	M ☐ F ☐
Current Address		Nationality:	
Residential Address			
Patient's contact number/s:			
Occupation:			
Name of the employer/ place of employment if self employed			
Date of consultation/admission	D D M M Y Y Y Y		

DOCTOR/HEALTH CARE PROVIDER'S DETAILS

Full		Contact	
Email Address:			
Facility Name:			
Region:		District	

NEXT OF KIN CONTACT DETAILS

Full Name:	Relationship to the pa ent:
Contact Number	

SIGNS AND SYMPTOMS (tick all that apply)

Symptomatic: **Yes/No** If Yes ☐ Fever (≥38 °C) ☐ Sore throat ☐ Diarrhea ☐ Loss of smell ☐ Chills ☐ Cough ☐ Shortness of breath ☐ Myalgia/body pains ☐ Vomiting
☐ Loss of taste ☐ Other (specify if other)______________ **Date of symptom onset:** ________/________/________

*Physical contact with a known COVID-19 case **Yes** ☐ **No** ☐ If yes indicate name and surname (If Known) ____________________
- **Unknown** ☐
- *Travel from countries, or other areas in Namibia where there is known COVID-19 community transmission **Yes** ☐ **No** ☐

Country	Region	City/Town	Date of departure (travel to area)	Date of return (travel from area)
			DD MM YYYY	DD MM YYYY

VACCINATION STATUS

Is the patient vaccinated? **Yes** ☐ No ☐ Name of Vaccine: ______________________________
Number of Doses: ☐ single dose vaccine ☐ 1st Dose ☐ 2nd Dose ☐ 3rd Dose ☐ Unknown Date of last vaccination:

MEDICAL HISTORY / CO-MORBIDITIES

Obesity ☐ Tuberculosis ☐ Chronic Kidney Disease ☐ Diabetes Mellitus ☐ Cardiovascular disease including Hypertension ☐ Pregnancy ☐ HIV ☐ Asthma ☐ Chronic Liver Disease ☐
COPD/Chronic Pulmonary disease ☐ Others ☐ (specify):________________________

Previously tested positive for COVID -19 ? **Yes** ☐ **No** ☐ If Yes add Date of confirmation: _______/____/_____
Presence of clinical or radiological pneumonia **Yes** ☐ **No** ☐ *Were chest X rays (CXR) done: **Y** ☐ **N** ☐ **CXR FIndings:** ________________________

Presence of clinical or radiological acute respiratory distress syndrome (ARDS) **Yes** ☐ **No** ☐
Presence of another diagnosis/etiology for their respiratory illness **Yes** ☐ (specify) ______________________ **No** ☐ **Unknown** ☐

TREATMENT / MANAGEMENT

Patient Hospitalised: **Yes** ☐ **No** ☐ **Uknown** ☐ Admitted to ICU: **Yes** ☐ **No** ☐ **Uknown** ☐ **Ventilation: Yes** ☐ **No** ☐ **Uknown** ☐ On ECMO: **Yes** ☐ **No** ☐ **Uknown** ☐ Transferred ☐ **Name of transferred facility** ______________________
Referred ☐ **Referral facility** ________________________ Discharged ☐ **Discharge date: ______/______/_______**

PATIENT OUTCOME

Active ☐ **Recovered** ☐ **Recovery date:**______________ **Died** ☐ **Date of death:**______________

Form completed by (Name & Signature	Contact details (Tel or Cell No)	Unit/Department