Florida HEALTH

Coronavirus Disease 2019 (COVID-19)
Interim Person Screening Form

This form may be used by county health departments for persons under investigation (PUI) for possible patients who meet the definition of a COVID-19 PUI. Please create a case in Merlin for each PUI identified. If you have questions after hours, contact the Florida Department of Health Bureau of Epidemiology at 850-245-4401.

Contact Information

use date format: (MM/DD/YY)

Merlin Case ID	CDC PUI Number	☐ New Report ☐ Update to previous report	Date CHD Notified (/ /) Report Date (/ /)
Reporting County	Interviewer Name	Interviewer Phone	Interviewer Email
Person Name (Last, First, M.I.):	Parent/Guardian Name (if Minor)		Person or Guardian Phone
Person Address: Number, Street, Apt #	City	County	State / ZIP Code
Facility (Hospital) Name	Facility Phone	IP's Name	Physician's Name
Facility Address: Number, Street, Floor	City	County	State / ZIP Code

How person was identified (check one)
☐ Clinician notified CHD ☐ Unusual lab result ☐ Ill traveler identified coming/returning to the US ☐ Other:_____

Demographic Information

use date format: (MM/DD/YY)

Date of Birth (/ /)	Age	Sex ☐ Male ☐ Female ☐ Other ☐ Unk
Race (check one) ☐ African-American/Black ☐ Asian/Pacific Islander ☐ Native American ☐ White ☐ Other: _____		Ethnicity (check one) ☐ Hispanic/Latino ☐ Non-Hispanic ☐ Unk
Usual Occupation	Industry	Does the person have any close contacts[1]? ☐Yes ☐No ☐Unk

Symptoms, Treatment

use date format: (MM/DD/YY)

Illness onset date (/ /)	Person was symptomatic at initial interview ☐Yes ☐No, date person felt back to normal: (/ /) ☐Unk

Primary symptoms person has experienced during illness:

Fever	☐Yes	☐No	☐Unk	Onset date (/ /) ☐Measured, highest temp: ____ ☐Subjective
Dry cough	☐Yes	☐No	☐Unk	Onset date (/ /)
Productive cough	☐Yes	☐No	☐Unk	Onset date (/ /)
Shortness of breath/dyspnea	☐Yes	☐No	☐Unk	Onset date (/ /)

Check all additional symptoms that the person has experienced during illness and include date of onset:

☐ Sore throat (/ /) ☐ Headache (/ /) ☐ Chills (/ /)

☐ Muscle aches (/ /) ☐ Nausea/vomiting (/ /) ☐ Abdominal pain (/ /)

☐ Diarrhea (/ /) ☐ Runny nose/rhinorrhea (/ /) ☐ Other, specify:_____ (/ /)

Check all diagnoses person has received and include date of diagnosis:

☐ Pneumonia (/ /) ☐ ARDS (/ /) ☐ Renal Failure (/ /)

☐ Abnormal chest X-ray (/ /) ☐ Other, specify: _____ (/ /)

Check all underlying health conditions of the person:

☐ Diabetes ☐ Chronic Lung Disease ☐ Chronic Kidney Disease ☐ Chronic Liver Disease ☐ Cardiac Disease

☐ Hypertension ☐ Immunocompromised, specify: _____ ☐ Neurologic/neurodevelopmental, specify: _____ ☐ Other, specify: _____

Person is pregnant ☐Yes ☐No ☐Unk

Current smoker ☐Yes ☐No ☐Unk | Former smoker ☐Yes ☐No ☐Unk

Patient has a non-COVID-19 etiology for their respiratory illness but has not responded to appropriate therapy ☐Yes, specify: _____ ☐No ☐Unk

Specify locations where person sought medical care for their illness:

Location	Earliest date (MM/DD/YY)	Details
☐ Doctor's Office		
☐ Health Department		
☐ Urgent Care Clinic		
☐ Emergency Department		
☐ Other		
☐ Unknown		

Was person hospitalized for this illness? ☐Yes, date of admission (/ /) ☐No ☐Unk

Did person die as a result of this illness? ☐Yes, date of death (/ /) ☐No ☐Unk

Risk Factors

In the 14 days before symptom onset:

Person traveled to or from geographic region with sustained community transmission	☐Yes ☐No ☐Unk	Destinations and dates including arrival to the US
Person had travel companions	☐Yes ☐No ☐Unk	Names and phone numbers of travel companions
Person traveled to or from mainland China	☐Yes ☐No ☐Unk	Destinations and dates including arrival to the US
In China, person in a health care facility as a patient, worker, or visitor	☐Yes ☐No ☐Unk	Dates and details of exposure
Patient is a health care worker in the US	☐Yes ☐No ☐Unk	

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Risk Factors

In the 14 days before symptom onset:

Person had close contact[1] with a laboratory-confirmed COVID-19 case	☐Yes ☐No ☐Unk	
Case was ill at time of contact	☐Yes ☐No ☐Unk	
Case was reported	☐in US ☐Outside US	If outside US, specify country

Types of contact:

Household contact	☐Yes ☐No ☐Unk
Community contact	☐Yes ☐No ☐Unk
Health care contact	☐Yes ☐No ☐Unk

Person status at time of health care contact with lab-confirmed COVID-19 case:

Patient	☐Yes ☐No ☐Unk
Visitor	☐Yes ☐No ☐Unk
Health care worker	☐Yes ☐No ☐Unk

Person is a member of a cluster of patients with medically attended respiratory illness of unknown etiology in which COVID-19 is being evaluated in consultation with state and local health departments ☐Yes ☐No ☐Unk	Person's relationship to each cluster member

Person Contact

If hospitalized:

Patient is/was in a negative pressure room ☐Yes ☐No ☐Unk	Patient admitted to ICU ☐Yes ☐No ☐Unk
Patient is/was in a private room ☐Yes ☐No ☐Unk	Patient on ECMO ☐Yes ☐No ☐Unk
Patient received mechanical ventilation (MV)/intubation ☐Yes, total days with MV:_____ ☐No ☐Unk	

PPE health care personnel used when caring for patient or obtaining specimens	☐ N95 Mask	☐ Facemask	☐ Gloves	☐ None
	☐ Surgical mask	☐ Eye Protection	☐ Gown	☐ Unk

At time of interview, person was currently at a health care facility ☐Yes ☐No ☐Unk

If yes:

Patient used surgical mask during transport within current health care facility ☐Yes ☐No ☐Unk

[1] Close contact is defined as a) being within approximately 6 feet (2 meters), or within the room or care area, of a COVID-19 case for a prolonged period of time while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection); close contact can include 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) while not wearing recommended personal protective equipment. 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 person with COVID-19 (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to those exposed in health care settings.

Testing

Specify all non-COVID-19 testing performed:

Test Type	Specimen Collection Date (MM/DD/YY)	Result
☐ Influenza: Rapid test		☐ A ☐ B ☐ Positive ☐ Negative ☐ Pending ☐ Other: _____
☐ Influenza: PCR		☐ A ☐ B ☐ Positive ☐ Negative ☐ Pending ☐ Other: _____
☐ Influenza: Other test		☐ A ☐ B ☐ Positive ☐ Negative ☐ Pending ☐ Other: _____
☐ Respiratory syncytial virus		☐ Positive ☐ Negative ☐ Pending
☐ Human metapneumovirus		☐ Positive ☐ Negative ☐ Pending
☐ Adenovirus		☐ Positive ☐ Negative ☐ Pending
☐ Parainfluenza 1-4		☐ Positive ☐ Negative ☐ Pending
☐ Rhinovirus/enterovirus		☐ Positive ☐ Negative ☐ Pending
☐ Coronavirus (OC43, 229E, HKU1, NL63)		☐ Positive ☐ Negative ☐ Pending
☐ *Legionella pneumophila*		☐ Positive ☐ Negative ☐ Pending
☐ *Streptococcus pneumoniae*		☐ Positive ☐ Negative ☐ Pending
☐ *Mycoplasma pneumoniae*		☐ Positive ☐ Negative ☐ Pending
☐ *Chlamydia pneumoniae*		☐ Positive ☐ Negative ☐ Pending
☐ Other: _____		☐ Positive ☐ Negative ☐ Pending
☐ Blood culture		Specify organisms

Specify all specimens collected for COVID-19 testing:

Specimen	Collection Date (MM/DD/YY)	Sent to BPHL
☐ Sputum		☐ Yes ☐ No
☐ Tracheal aspirate (TA)		☐ Yes ☐ No
☐ Bronchial alveolar lavage (BAL)		☐ Yes ☐ No
☐ Nasopharyngeal (NP)		☐ Yes ☐ No
☐ Oropharyngeal (OP)		☐ Yes ☐ No
☐ Serum		☐ Yes ☐ No
☐ Stool		☐ Yes ☐ No
☐ Urine		☐ Yes ☐ No
☐ Other: _____		☐ Yes ☐ No

Other Notes