DATA PRIORITY KEY

Priority 1: Map Data

1. First Name
2. Last Name
3. Date of Birth
4. Current Sex
5. State
6. County
7. Jurisdiction
8. Investigation Start Date
9. Date Patient Was Released from Isolation
10. Investigation Status
11. Investigator
12. Date Assigned to Investigation
13. Was the patient hospitalized for this illness?
14. Admission Date (can leave blank if 12 is no)
15. Discharge Date (can leave blank if 12 is no)
16. Did the patient die from this illness?
17. School/University/Childcare Center Exposure
18. What is the name of the school/university/childcare center?
19. Case Status

Priority 2: Grant Data

1. Was the patient interviewed within 24 hours of identification?
2. Total number of contacts
3. How many contacts were notified within 24 hours?
4. How many contacts were tested for COVID-19 within 14 days?
5. How many identified contacts tested positive for COVID-19?

Priority 3: Epi-Curve Data

1. Ethnicity information as of date
2. Ethnicity
3. Does the case have any tribal affiliation?
4. Enrolled tribal member
5. Tribal name
6. Race information as of date
7. Race
8. Did the patient develop pneumonia?
9. Did the patient have acute respiratory distress syndrome?
10. Did the patient have another diagnosis/etiology for their illness?
11. Did the patient have an abnormal chest x-ray?
12. Did the patient have an abnormal EKG?
13. Was the patient admitted to an intensive care unit (ICU)?
14. ICU Admission Date
15. ICU Discharge Date
16. Is the patient part of a cluster of COVID-19 individuals?
17. What is the name of the COVID-19 cluster?
18. Is the patient a health care worker in the United States?
19. Adult congregate living facility
20. Correctional facility
21. Domestic travel
22. If yes, specify state
23. International travel
24. If yes, specify country
25. Did the patient have contact with another COVID-19 case?
26. Household contact
27. Community contact
28. Healthcare contact
29. Community Event/Mass Gathering
30. School/university/childcare center exposure
31. Detection method
32. Control measures implemented date
33. Patient lost to follow up
34. Symptoms present during course of illness
35. Date of symptom onset
36. Onset date could not be determined

37. Date of symptom resolution
38. Pre-existing medical conditions?
39. Laboratory Testing Performed

View Investigation: 2019 Novel Coronavirus (COVID-19)

Test A Test B | Male | 01/02/2020 (9 Months)		**Patient ID:** 933199
Investigation ID: CAS10607032MT01	**Created:** 09/23/2020	**By:** Lauren England
Investigation Status: Open	**Last Updated:** 09/23/2020	**By:** Lauren England
Investigator: Lauren England	**Case Status:** Confirmed	**Notification Status:** PEND_APPR

*** Indicates a Required Field**

Patient Information

General Information

*** Information As of Date:** 09/23/2020
Comments:

Name Information

Name Information As Of Date: 09/23/2020
First Name: Test A
Middle Name:
Last Name: Test B
Suffix:

Other Personal Details

Other Personal Details As Of Date: 09/23/2020
*** Date of Birth:** 01/02/2020
Reported Age: 8
Reported Age Units: Months
Country of Birth:
Current Sex: Male
Mortality Information As Of Date: 09/23/2020
Is the patient deceased?: No
Deceased Date:
Marital Status As Of Date: 09/23/2020
Marital Status: Single, never married

Reporting Address for Case Counting

Address Information As Of Date: 09/23/2020
Street Address 1: 1111 1st Ave West
Street Address 2:
City: Kalispell
*** State:** Montana
Zip:
*** County:** Flathead County
Country: UNITED STATES

Telephone Information

Telephone Information As Of Date:
Home Phone:
Work Phone:
Ext.:
Cell Phone:
Email:

Ethnicity and Race Information

Ethnicity Information As Of Date:
Ethnicity:
Does this case have any tribal affiliation?:
Enrolled Tribal Member?:
Tribe Name(s):
Race Information As Of Date: 09/23/2020
Race: White

Investigation Information

Investigation Details

These fields are required data elements for case reporting.

Jurisdiction: FLATHEAD
Program Area: General Communicable Diseases

Investigation Details

Investigation Start Date: 09/23/2020
Was the patient interviewed within 24 hours of identification?:
Total Number of Contacts: 3
How many contacts were notified within 24 hours?:
Number of Contacts Tested for COVID-19 within 14 Days of Notification:
How many contacts tested positive for COVID-19?:
Date Patient Was Released from Isolation:
Investigation Status: Open
Shared Indicator: Yes

COVID-19 Case Details

The Montana Department of Health Will Assign the CDC 2019-nCoV ID.

CDC 2019-nCoV ID:
Source patient case ID:

These fields are required data elements for case reporting.

What is the current status of this person?: Laboratory-confirmed case
Report Date of PUI to CDC: 09/23/2020
Report Date of Case to CDC: 09/23/2020
Under what process was the case first identified?: Clinical evaluation
Other Under what process was the case first identified?:
DGMQ ID:
Information Source for Clinical Information (check all that apply):

Investigator

Investigator: Lauren England
1035 1st Ave. W.
Kalispell, Montana 59901
Date Assigned to Investigation: 09/23/2020

Reporting Information

Key Report Dates

Date of Report: 09/23/2020
Earliest Date Reported to County: 09/23/2020
Earliest Date Reported to State: 09/23/2020

Reporting Organization

Reporting Source Type: Laboratory
Reporting Organization: KALISPELL REGIONAL Medical Center
MICRO LABORATORY
310 SUNNYVIEW LANE
Kalispell, Montana 59901-0000
406-756-3524
406-752-1737

Reporting Provider

Reporting Provider:

Reporting County

Reporting County: Flathead County

Clinical

Physician

Physician:

Clinical Findings

These fields are required data elements for case reporting.

Date of first positive specimen collection: 09/20/2020
Did the patient develop pneumonia?: Unknown
Did the patient have acute respiratory distress syndrome?: Unknown
Did the patient have another diagnosis/etiology for their illness?: Unknown
Did the patient have an abnormal chest X-ray?: Unknown
Did the patient have an abnormal EKG?: Unknown

Hospital

These fields are required data elements for case reporting.

Was the patient hospitalized for this illness?: No
Hospital:
Admission Date:

Hospital

If hospitalized, was a translator required?:	
If yes, specify which language:	
Discharge Date:	
Total Duration of Stay in the Hospital (in days):	
Was the patient admitted to an intensive care unit (ICU)?:	
ICU Admission Date:	
ICU Discharge Date:	
Did the patient die from this illness?:	No
Date of Death:	
Unknown Date of Death:	

Condition

Diagnosis Date:	

Epidemiologic

Epi-Link

These fields are required data elements for case reporting.

Is the patient part of a cluster of COVID-19 individuals?:	
What is the name of the COVID-19 cluster?:	
Is the patient a health care worker in the United States?:	
If yes, what is their occupation (type of job)?:	
Other If yes, what is their occupation (type of job)?:	
If yes, what is their job setting?:	
Other If yes, what is their job setting?:	
Patient history of being in a healthcare facility (as a patient, worker or visitor) in China?:	
Adult Congregate Living Facility (nursing, assisted living, or LTC facility):	
Correctional Facility:	

Exposure Information

These fields are required data elements for case reporting.

In the 14 days prior to illness onset, did the patient have any of the following exposures (indicate all that apply):

Workplace:	
If yes, is the workplace critical infrastructure (e.g. healthcare setting, grocery store)?:	
If yes, specify workplace setting:	
Did the patient travel to any high-risk locations:	
Domestic travel (outside normal state of residence):	Unknown
If yes, specify state(s):	
International Travel:	Unknown
Specify Country(s):	
Did the patient have contact with another COVID-19 case (probable or confirmed)?:	
If the patient had contact with another COVID-19 case, was this person a U.S. case?:	
nCoV ID of source case 1:	
nCoV ID of source case 2:	
nCoV ID of source case 3:	
Household contact:	
Community contact:	
Healthcare contact:	
Type of healthcare contact:	
Community Event/Mass Gathering:	
Cruise ship or vessel travel as passenger or crew member:	
Specify Name of Ship or Vessel:	
Airport/Airplane:	
Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology:	
School/University/Childcare Center Exposure:	**Yes**
What is the name of the school/university/childcare center?:	**Rossiter Middle School**
Animal with confirmed or suspected COVID-19:	
Specify Type of Animal:	
Other Exposure:	
Other Exposure Specify:	
Unknown exposures in the 14 days prior to illness onset:	

Disease Acquisition

Where was the disease acquired?:	
Imported Country:	

Disease Acquisition

Imported State:
Imported City:
Imported County:
Country of Usual Residence:
Which would best describe where the patient was staying at the time of illness onset?:
Other Which would best describe where the patient was staying at the time of illness onset?:

Exposure Location

	Country of Exposure	State or Province of Exposure	City of Exposure	County of Exposure
No Data has been entered.				

These fields are required data elements for case reporting.

Country of Exposure:
State or Province of Exposure:
City of Exposure:
County of Exposure:

Binational Reporting

Binational Reporting Criteria:

Case Status

These fields are required data elements for case reporting.

Transmission Mode: Droplet
Detection Method: Patient self-referral
Confirmation Method: Laboratory confirmed
Confirmation Date: 09/23/2020
Case Status: Confirmed
If probable, select reason for case classification:
MMWR Week: 39
MMWR Year: 2020
If yes, describe:
Control Measures Implemented Date:
Patient Lost to Follow-up?: No

General Comments

General Comments

General Comments:

Signs & Symptoms

Symptoms

These fields are required data elements for case reporting.

Symptoms present during course of illness: Yes
Date of Symptom Onset: 09/19/2020
Onset date could not be determined:
Date of Symptom Resolution:
If symptomatic, symptom status:
Illness Duration:
Illness Duration Units:
Age at Onset: 8
Age at Onset Units: Months

Symptom Details

These fields are required data elements for case reporting.

Fever >100.4F (38C):
Highest Measured Temperature:
Subjective fever (felt feverish):
Chills:
Rigors:
Muscle aches (myalgia):
Runny nose (rhinorrhea):
Sore Throat:
New Olfactory and Taste Disorder:
Headache:
Fatigue or malaise:
Cough (new onset or worsening of chronic cough):

Symptom Details

Wheezing:
Shortness of Breath (dyspnea):
Difficulty Breathing:
Chest Pain:
Nausea or Vomiting:
Abdominal Pain or Tenderness:
Diarrhea (=3 loose/looser than normal stools/24hr period):
Loss of appetite:
Other symptom(s)?:
Other Symptoms:

Medical History

Pre-Existing Conditions

These fields are required data elements for case reporting.

Pre-existing medical conditions?:

Medical History

Diabetes Mellitus:
Hypertension:
Severe Obesity (BMI >=40):
Cardiovascular disease:
Chronic Renal disease:
Chronic Liver disease:
Chronic Lung Disease (asthma/emphysema/COPD):
Other Chronic Diseases:
Specify Other Chronic Diseases:
Other Underlying Condition or Risk Behavior:
Specify Other Underlying Condition or Risk Behavior:
Immunosuppressive Condition:
Autoimmune Condition:
Current smoker:
Former smoker:
Substance Abuse or Misuse:
Disability:
Specify Disability:
Psychological or Psychiatric Condition:
Specify Psychological or Psychiatric Condition:
Is the patient pregnant?:
Due Date:

Respiratory Diagnostic Testing

Laboratory Information

These fields are required data elements for case reporting.

Laboratory Testing Performed: Yes

Respiratory Diagnostic Testing

Influenza A Rapid Ag:
Influenza B Rapid Ag:
Influenza A PCR:
Influenza B PCR:
RSV:
H. metapneumovirus:
Parainfluenza (1-4):
Adenovirus:
Rhinovirus/enterovirus:
Coronavirus (OC43, 229E, HKU1, NL63):
M. pneumoniae:
C. pneumoniae:
Were Other Pathogen(s) Tested?:

Symptom Notes

Symptom Notes:

Other Pathogens Tested

	Specify Other Pathogen Tested	Other Pathogens Tested
No Data has been entered.		

Other Pathogens Tested

Specify Other Pathogen Tested:
Other Pathogens Tested:

Contact Records

Contacts Named By Patient

The following contacts were named within Test A Test B's investigation:

Date Named	Contact Record ID	Name	Priority	Disposition	Investigation ID
Nothing found to display.					

Patient Named By Contacts

The following contacts named Test A Test B within their investigation and have been associated to Test A Test B's investigation:

Date Named	Contact Record ID	Named By	Priority	Disposition	Investigation ID
Nothing found to display.					

Associations

Associated Lab Reports

Date Received	Reporting Facility/Provider	Date Collected	Test Results	Program Area	Event ID
09/23/2020 12:00 AM	**Reporting Facility:** KALISPELL REGIONAL Medical Center	09/21/2020	**SARS coronavirus 2 RNA:** detected	General Communicable Diseases	OBS11489838MT01

Associated Morbidity Reports

Date Received	Condition	Report Date	Type	Observation ID
Nothing found to display.				

Associated Treatments

Date	Treatment	Treatment ID
Nothing found to display.		

Associated Vaccinations

Date Administered	Vaccine Administered	Vaccination ID
Nothing found to display.		

Associated Documents

Date Received	Type	Purpose	Description	Document ID
Nothing found to display.				

Notes And Attachments

Notes

Date Added	Added By	Note	Private
Nothing found to display.			

Attachments

Date Added	Added By	File Name	Description
Nothing found to display.			

History

Investigation History

	Change Date	User	Jurisdiction	Case Status	Version
	09/23/2020	Lauren England	FLATHEAD	Confirmed	2

Notification History

	Status Change Date	Date Sent	Jurisdiction	Case Status	Status	Type	Recipient

Notification History

	Status Change Date	Date Sent	Jurisdiction	Case Status	Status	Type	Recipient
	09/23/2020		FLATHEAD	Confirmed	PEND_APPR	NND Individual Case Notification	CDC
	Comments:						