DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-02719 (08/2021)

STATE OF WISCONSIN

COVID-19 INITIAL CASE INTERVIEW

Reset Form

If you find that **the case is past isolation**, skip all questions shaded in tan.

WEDSS ID	**CASE-PATIENT NAME**

WEDSS Outbreak ID

Local or Tribal Health Department Jurisdiction	**Local or Tribal Health Department Phone Number**

Interview Information

Date of Interview (MM/DD/YYYY)	Name of interviewer

Agency completing interview (*Local Health Department or DHS Tracing Team*)

Who is providing information to interviewer? ☐ Case-Patient ☐ Other	Specify person (Name- Last, First)	Relationship to case-patient

Notes:

Case-Patient Contact Information

Patient Name – Last	First	Middle Initial

Home Street Address	Apartment No

City	County	State	Zip	Country

Home Telephone Number	Cell Phone Number	Email Address

Primary Language	Ethnicity	Race

Date of Birth (or Age, if DOB is unknown) / / Age: years months	Sex ☐ Male ☐ Female	Gender ☐ Transgender: ☐ Male to Female ☐ Female to Male

If case is female and of childbearing age (14-55), please ask:
Are you pregnant now or were you pregnant at the time of your infection with COVID19? ☐ Yes ☐ No ☐ Unknown
If yes, please enter the estimated delivery date:

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Laboratory and Clinical Information [*WEDSS tab: 2019-nCoV LabClinical*]

Reason Patient Was Tested for COVID-19

Select all that apply:

- ☐ Is/was having symptoms of COVID-19
- ☐ Had upcoming surgery/procedure and was asymptomatic
- ☐ Is/was a close contact to someone with COVID-19
- ☐ Travel
- ☐ Lives or works at a location that has/had an outbreak (e.g. nursing home, corrections facility, workplace)
- ☐ Patient presented for testing at a community testing site
- ☐ Other Please specify:

When did your symptoms begin? Date of symptom onset:
(This refers to the first day the patient began to feel sick, which could include new or worsening cough, sore throat, runny nose, fever, headache, or shortness of breath)

Symptoms

Which of the following symptoms have you experienced? Please check all that apply. **This should include all symptoms the case has had throughout their illness**

Symptom	Symptom Present	Symptom Resolved at Time of Interview
None, if **none**, enter date the test was administered:	☐	☐
Cough	☐	☐
Sore throat	☐	☐
Runny nose (rhinorrhea)	☐	☐
Nasal congestion	☐	☐
Shortness of breath (dyspnea) or trouble breathing*	☐	☐
Fever (temperature of at least 100.4F/ 38C or felt feverish)	☐	☐
Chills	☐	☐
Headache	☐	☐
Muscle aches (myalgia)	☐	☐
Fatigue	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Diarrhea (>3 loose stools/day)	☐	☐
Abdominal pain	☐	☐
Loss of smell	☐	☐
Loss of taste	☐	☐
Persistent pain or pressure in the chest*	☐	☐
New confusion or the inability to be woken*	☐	☐
Pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone*	☐	☐
Other, specify:		

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	Yes	No	Unknown
Is client **currently (at time of interview**) experiencing any emergency warning signs of COVID-19 or expressing concern about other symptoms that they are experiencing	☐	☐	☐
At the time of the interview, did the case meet the "well" definition (fever-free for 24 hours without using fever-reducing medication and marked improvement in other symptoms)?	☐	☐	☐

What **date** did the client meet the **symptom criteria** for release from isolation?

Notes:

Do you have any of the following medical conditions? Check all that apply.	
Medical Condition	**Condition(s) Present?**
No medical conditions	☐
Diabetes	☐
Hypertension (high blood pressure)	☐
Emphysema	☐
Cardiac (heart) disease	☐
Asthma	☐
Chronic kidney disease	☐
Other chronic pulmonary disease Please specify:	☐
Chronic liver disease	☐
Immunocompromised (*any condition, including immune suppressing medications and treatments, that puts you at higher risk of infection*)	☐
Neurological/neurodevelopmental disease Please specify	☐
Other, specify:	☐

Other laboratory/clinical questions	**Yes**	**No**	**Unknown**
Did the case-patient have clinical or radiologic evidence of pneumonia?	☐	☐	☐
Did case-patient have an abnormal chest X-ray?	☐	☐	☐
Was the case-patient diagnosed with acute respiratory distress syndrome (ARDS)?	☐	☐	☐

Is the case-patient a current or former smoker?
☐ Current ☐ Former ☐ Never smoked ☐ Unknown

Notes:

Health Insurance	**Yes**	**No**	**Unknown**
Does the patient have health insurance?	☐	☐	☐

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Medical Provider Information [WEDSS Section Medical Care Providers (2019-nCoV)]

Did you go to the doctor for any of the symptoms you experienced?
☐ Yes ☐ No ☐ Unknown
Note: This includes testing at a clinic or hospital. If patient received drive-thru or community testing, please skip this section and go to Symptom Self-Monitoring.

What type of medical care was sought? ☐ Outpatient ☐ Inpatient

Clinic/hospital/provider name	Provider Phone number

Date of clinic visit/hospital admission	Date of inpatient discharge

Admitted to the Intensive Care Unit (ICU)	Intubated	On ECMO (life support)
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Laboratory and Clinical Information Notes:

Symptom Self-Monitoring

Is the case willing to self-monitor their symptoms by email or text message?	☐ Yes	☐ No
If **Yes,** please enter their preferred email address or cell number:		

Indicate one morning, A.M. and one evening P.M. reporting time

A.M. reporting time:			**P.M.** reporting time:		
☐ 5am	☐ 6am	☐ 7am	☐ 12pm	☐ 1pm	☐ 2pm
☐ 8am	☐ 9am	☐ 10am	☐ 3pm	☐ 4pm	☐ 5pm
☐ 11am			☐ 6pm		

Comments:

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Residential settings	Yes	No	Unknown
Are you currently living in stable housing situation?	☐	☐	☐
Where does the case-patient live?			
Group or congregate setting where multiple unrelated people reside (e.g. long-term care facility, jail, prison, dormitory; this may or may not be a licensed or inspected facility) If **Yes**, type of setting: _____ If **other**, please specify name, address, and details of group residence:	☐	☐	☐
Single family home?	☐	☐	☐
Apartment/condo/duplex/townhome? If **Yes**, does it have a common entrance or shared spaces?	☐	☐	☐
How many other people live in the same home/apartment/condo? How many:			
Do you have any pets or responsibilities caring for animals?	☐	☐	☐

Intervention [WEDSS Tab 2019-nCoV Intervention]

Isolation and Quarantine	Yes	No	Unknown
Is the case-patient isolated? If **yes**, please note the start and end date of isolation (if known) Isolation start date: Isolation end date:	☐	☐	☐
Employer/School/Other notified of isolation?	☐	☐	☐
Is the case-patient isolated at own residence? If **No**, address of location person is being isolated/quarantined	☐	☐	☐
Were isolation orders issued? Note: this is only for LTHD use Date isolation order was issued:	☐	☐	☐
Do you think you will be able to separate yourself from other people and from animals where you live? Review home isolation instructions.	☐	☐	☐
Is the client safe at home while in isolation/quarantine? ☐ Declined to answer	☐	☐	☐
Do you have needs related to any of the following resources while you are in isolation? *If they say yes to any of the following, please refer them to 2-1-1 resources.*			
Food	☐	☐	☐
Bills	☐	☐	☐
Personal care items/Medications	☐	☐	☐
Cleaning supplies	☐	☐	☐
Other needs – please specify:	☐	☐	☐

Additional information:

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COVID19 Risks [WEDSS Tab 2019-nCoV Risk]

Current Occupation and Industry

For each currently held job (paid employment), provide 1) Occupation, 2) Industry, and 3) Place of employment. If client does not have paid employment (retired, volunteer, student, unemployed, homemaker), enter "Not employed" for Occupation. Enter "unknown" for occupation if not known.

Occupation 1 (Patient's job for example: registered nurse, janitor, cashier, auto mechanic)	**Industry** (What does the company make or do? For example: hospital, elementary school, paper mill)

Employer name

Employer Street Address	City	State	Zip

Where is the job performed? ☐ At the job site ☐ Remotely ☐ Both

Last date worked:

Did the patient work at this job in the 14 days before symptom onset/positive test?
☐ Yes ☐ No ☐ Unknown

If **Yes**, what dates and times were worked, duties performed, or any other relevant information.

Did the patient work at this job while infectious?
☐ Yes ☐ No ☐ Unknown

Occupation 2 (Patient's job for example: registered nurse, janitor, cashier, auto mechanic)	**Industry** (What does the company make or do? For example: hospital, elementary school, paper mill)

Employer name

Employer Street Address	City	State	Zip

Where is the job performed? ☐ At the job site ☐ Remotely ☐ Both

Last date worked:

Did the patient work at this job in the 14 days before symptom onset/positive test? ☐ Yes ☐ No ☐ Unknown

If **Yes**, what dates and times were worked, duties performed, or any other relevant information.

Did the patient work at this job while infectious? ☐ Yes ☐ No ☐ Unknown

Work or Volunteer while Patient was INFECTIOUS

1-Job worked or volunteered while infectious. The following questions refer to the time-period when the patient was considered infectious (two days before symptom onset/date of 1st positive test until patient entered isolation).

Date of symptom onset: Start of infectious period:

Date of work or volunteer start:	Date of work or volunteer end:
Activity setting: ☐ Inside ☐ Outside	Estimated number of people in attendance:
Point of Contact Name	Point of Contact Phone Number

Additional information/details:

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Current Occupation and Industry (continued)

2-Job worked or volunteered while infectious. The following questions refer to the time-period when the patient was considered infectious (two days before symptom onset/date of 1st positive test until patient entered isolation).

Date of symptom onset: Start of infectious period:

Date of work or volunteer start:	Date of work or volunteer end:
Activity setting: ☐ Inside ☐ Outside	Estimated number of people in attendance:
Point of Contact Name	Point of Contact Phone Number

Additional information/details:

Employment Summary	Yes	No	Unknown
Is the case-patient a healthcare worker?	☐	☐	☐
Is the patient a teacher (preschool, K-12, college/university)?	☐	☐	☐
Is the case-patient a member of law enforcement?	☐	☐	☐
Is the case-patient a first responder/fire/EMS provider?	☐	☐	☐
Does the case-patient work in a group or congregate living setting? If Yes, select setting type: If Other, please specify: Name, address, and details for group residence:	☐	☐	☐
In the 14 days before symptom onset/positive test, did the case-patient do any volunteer work?	☐	☐	☐

Please list organization and location of volunteer work:

Education and Child Care	Yes	No	Unknown
Attends child care as a client/attendee Date last attended in person:	☐	☐	☐
Facility Name / Facility Address			
Did client attend child care in the 14 days before onset/collection date?	☐	☐	☐
Did client attend child care during their infectious period?	☐	☐	☐

Details

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Education and Child Care (continued)	Yes	No	Unknown
Attends school/college/university as a student If **Yes**, was it: ☐ In-person ☐ Virtual/distance learning only ☐ Hybrid (in-person and virtual mixed) Date last attended in person:	☐	☐	☐

Name of School/college/university	Grade/Year	City and State

Did client attend in-person school/college/university in 14 days before onset/collection date	☐	☐	☐
Did client attend in-person school/college/university during their infectious period	☐	☐	☐
Details			
Participates in any school-sponsored athletics or team sports If **Yes**, which sports: If **Yes**, name of school/club/team, details, dates played or practices:	☐	☐	☐
Participates in any school-sponsored activities other than sports, such as band, chorus, speech/debate, subject specific clubs, etc. If **Yes**, which activities:	☐	☐	☐

Travel History	Yes	No	Unknown
Any **International** travel in the 14 days before onset/collection date If **Yes**, Details (what countries, dates of travel and date returned to U.S.)	☐	☐	☐
Any **Domestic** travel **(outside WI within US)** in the 14 days before onset/collection date If **Yes**, Details (what states, dates of travel and where did they stay/do)	☐	☐	☐
Any travel **in Wisconsin** in the 14 days before onset/collection date If **Yes**, Details (Where traveled, dates of travel, activities)	☐	☐	☐
Any air travel during their **infectious period**?	☐	☐	☐

For each flight while infectious, collect AS MUCH INFORMATION AS AVAILABLE about flight date, time, number, airline, seat number (or estimate of where they sat), arrival and departure city and or airport.

Flight 1:

Flight 2:

Flight 3:

Do you have any upcoming travel plans in the next 3 weeks? *Inform client that they cannot travel **during their infectious or quarantine period**. If client indicates they do plan to travel regardless of this guidance, please document their intentions.* Details of travel plans (dates and locations, etc.)	☐	☐	☐

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Contact Tracing (*Activities while infectious*)

Now, we are going to try and determine who might have been exposed to COVID-19 during your infectious period. Please think of all activities, places visited, travel, and individuals seen during the **2 days** before your symptom onset (**2 days** before the date of specimen collection for a confirmed or probable asymptomatic case) until the last day of your isolation or until the date of this interview if still within infectious period.
Note: *Enter data from this section in the WEDSS Tab: 2019-nCoV Risk. This section also helps identify contacts.*

NOTE: If case went to work or caused an exposure while infectious, capture enough information to allow for public health follow-up including names, location details, contact information (including phone number), inside/outside, and number of attendees.

Symptom onset or positive test date if asymptomatic: **2 days prior:**

End of isolation period or today's date, whichever is earlier:

Daily Activity History

Details	2 days prior:	1 day prior:	**Symptom onset/positive test date if asymptomatic**	Day 1
Details	Day 2	Day 3	Day 4	Day 5

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Contact tracing daily activities continued.

Details	Day 6	Day 7	Day 8	Day 9
Details	Day 10	Day 11	Day 12	Day 13
Details	Day 14	Day 15	Day 16	Day 17

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Contacts

Using your daily Activity History (from page 9), list anyone who you had close contacts with during this period. (This should only be during the case's infectious period.)

- Infectious period:
  - **For confirmed or probable symptomatic patients: 2 days** before symptom onset through when the patient began their isolation (OR discontinued home isolation for household contacts where isolation could not be implemented)
  - **For confirmed or probable asymptomatic patients: 2 days** before the date of specimen collection for confirmed laboratory test through when the patient began their isolation (OR discontinued home isolation for household contacts where isolation could not be implemented)
- Use the "Risk Assessment Flow Chart" to determine if the contacts meets the definition of close contact. Each close contact **will be notified** of their potential exposure and will be educated on self-quarantine and self-monitoring as needed.

Name: Last, First (if last name is unknown enter 'UNKNOWN')	**Primary Language**	**Phone number**	**Relationship to Case-patient**	**Sex**	**Age/ DOB**	**Date of last exposure** (if case is symptomatic and there is on-going exposure, put "on-going" and do not put a date)	**Address** (street address if known, city, state)	**Has the contact reported any COVID-like symptoms recently?** If **yes**, please **list date** of illness onset if known. Please note if the contact was diagnosed with COVID-19.	***For Interviewer*** Was contact notification completed for HH contact at the time of index case interview?
	Details of exposure								
	Details of exposure								
	Details of exposure								
	Details of exposure								

Name: Last, First (if last name is unknown enter 'UNKNOWN')	**Primary Language**	**Phone number**	**Relationship to Case-patient**	**Sex**	**Age/ DOB**	**Date of last exposure** (if case is symptomatic and there is on-going exposure, put "on-going" and do not put a date)	**Address** (street address if known, city, state)	**Has the contact reported any COVID-like symptoms recently?** If **yes**, please **list date** of illness onset if known. Please note if the contact was diagnosed with COVID-19.	***For Interviewer*** Was contact notification completed for HH contact at the time of index case interview?
	Details of exposure								
	Details of exposure								
	Details of exposure								
	Details of exposure								
	Details of exposure								
	Details of exposure								

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Recreational Activities During 14 Days BEFORE Onset/Positive Test (non-work/volunteer related)	Yes	No	Unknown
Onset date/test collection date if asymptomatic: **14 days** before:			
In the 14 days before symptom onset/positive test, did the case-patient attend a gathering, party, or meeting with people from outside their household? If **Yes**, was anyone who attended the activity ill, or become ill afterwards? Details:	☐	☐	☐
In the 14 days before symptom onset/positive test, did the patient participate in any athletics or team sports, NOT school-sponsored, including adult league, youth, club, etc. If **Yes**, what sport(s)	☐	☐	☐

Name of club/team	Date(s) Played/Practice	Details

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In the 14 days BEFORE symptom onset or positive test, document the case-patient's (non-work) activities, especially important are those where the case-patient thinks they may have been exposed to COVID-19?

Name of event or gathering	Location (address, city)	Name of organizer or contact person and phone number	Activity setting (inside, outside, or both)	Estimated No. of people in attendance	Date(s) of event or gathering	Details of event or gathering
Comments:						
Comments:						
Comments:						
Comments:						
Comments:						
Comments:						
Comments:						
Comments:						
Comments:						
Comments:						
Comments:						

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EXPOSURE/SOURCE

Symptom onset/test collection date if asymptomatic: **14 days before symptom onset:**

In this section, we are trying to determine who exposed the individual or where the individual may have contracted COVID-19.

Did you have known close contact with a person diagnosed with COVID-19 in the 14 days before your illness onset (or collection date if asymptomatic)?

☐ **Yes** ☐ **No** ☐ **Unknown**

If yes, ☐ Household contact(s) ☐ Non-household contact(s) ☐ Both household and non-household contacts

If yes, please list the individuals you interacted with that were ill or a known case before your symptoms began.

Name: Last, First	Phone number	Occupation (if known)	Relationship to case-patient	Sex	Age	Date of last exposure	Were they diagnosed with COVID-19?

Do you know, or have a strong suspicion, where/how you were exposed? ☐ **Yes** ☐ **No** ☐ **Unknown**

If Yes, provide details of where the client believes their exposure occurred. (dates, location, circumstance, etc.)

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EXPOSURE/SOURCE OF ILLNESS [WEDSS SECTION 2019-nCoV – Risk]

The following section should be completed by the interviewer based on professional assessment of all the information collected during the client interview. Selection of a top choice for likely location of exposure should take in to consideration all reported epidemiologic risk factors, incubation, duration and nature of exposures and activities. Selection of a top choice should not be interpreted as confirmation or definitive proof of the source of infection, but instead an opportunity to provide an informed judgement when possible.

What is the top choice for the most likely location of exposure (if unknown, select undetermined):

If Other:

Activity Setting: ☐ Inside ☐ Outside ☐ Both

If **Work** was selected as the most likely location of exposure, please verify that the Occupation and Industry section was completed for that job. If more than one job/volunteer activity was reported by client, indicate which location is believed to be the source.

Specify job/location:

Health Teaching provided to case-patient (Please select all that apply)

☐ Test results or interpretation of test results	☐ Disease prevention measures
☐ Treatment options or countermeasures	☐ Other, please specify:
☐ Fact sheets offered	☐ Reviewed isolation instructions
☐ Information found on the internet	☐ Disease signs and symptoms

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Notes