CATALYST HEALTH NETWORK
8277 Belleview Drive
Plano, TX 75024

COVID-19 TESTING PROCEDURE
COMPLETING A PUI FORM

1. Patient Name and Date of Birth

CDC 2019-nCoV ID: ☐ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ____/_____/_____

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....

Human Infection with 2019 Novel Coronavirus
Person Under Investigation (PUI) and Case Report Form

2. Symptoms Present

Symptoms present during course of illness:
☐ Symptomatic
☐ Asymptomatic
☐ Unknown

a. If Symptomatic: Collect information on exposure
b. If Asymptomatic: Complete if patient is a healthcare worker

Symptoms present during course of illness: ☐ Symptomatic ☐ Asymptomatic ☐ Unknown	If symptomatic, onset date (MM/DD/YYYY): ____/_____/_____ ☐ Unknown	If symptomatic, date of symptom resolution (MM/DD/YYYY): ____/_____/_____ ☐ Still symptomatic ☐ Unknown symptom status ☐ Symptoms resolved, unknown date

Is the patient a health care worker in the United States? ☐ Yes ☐ No ☐ Unknown
Does the patient have a history of being in a healthcare facility (as a patient, worker or visitor) in China? ☐ Yes ☐ No ☐ Unknown
In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):

☐ Travel to Wuhan
☐ Travel to Hubei
☐ Travel to mainland China
☐ Travel to other non-US country specify:_____
☐ Household contact with another lab-confirmed COVID-19 case-patient
☐ Community contact with another lab-confirmed COVID-19 case-patient
☐ Any healthcare contact with another lab-confirmed COVID-19 case-patient ☐ Patient ☐ Visitor ☐ HCW
☐ Animal exposure
☐ Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology
☐ Other, specify:_____
☐ Unknown

If the patient had contact with another COVID-19 case, was this person a U.S. case? ☐ Yes, nCoV ID of source case: _____ ☐ No ☐ Unknown ☐ N/A

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3. Preexisting Conditions

Pre-existing medical conditions?

Chronic Lung Disease (asthma/emphysema/COPD)	☐ Yes	☐ No	☐ Unknown
Diabetes Mellitus	☐ Yes	☐ No	☐ Unknown
Cardiovascular disease	☐ Yes	☐ No	☐ Unknown
Chronic Renal disease	☐ Yes	☐ No	☐ Unknown
Chronic Liver disease	☐ Yes	☐ No	☐ Unknown
Immunocompromised Condition	☐ Yes	☐ No	☐ Unknown
Neurologic/neurodevelopmental/intellectual disability	☐ Yes	☐ No	☐ Unknown
Other chronic diseases	☐ Yes	☐ No	☐ Unknown
If female, currently pregnant	☐ Yes	☐ No	☐ Unknown
Current smoker	☐ Yes	☐ No	☐ Unknown
Former smoker	☐ Yes	☐ No	☐ Unknown