Ministry of Health

Suspected 2019- nCoV Notification Form

1. Reporting hospital: | **2. Date of reporting:** | Hosp. Sticker

3. Patient name:

4.Nationality: | **5.GSM:**

6.1 Governorate: | **6.2 Wilayat:** | **6.3 Village:**

7.1 Symptoms: ☐ Fever ☐ Runny Nose ☐ Sneezing ☐ Cough ☐ Sore Throat
☐ Shortness of Breath ☐ Other symptoms:______________________

7.2 Date of onset: ____/____/_______ **7.3 Date of Admission:** ____/____/_______

8. Did patient travel outside Oman in the 14 days prior to illness onset? ☐ Yes ☐ No ☐ Unknown

If yes, provide details:

	Depart Date	**Return Date**	**Country**
1.	____/____/_______	____/____/_______	______________
2.	____/____/_______	____/____/_______	______________

9. Did patient have contact with someone else who traveled outside Oman in the 14 days prior to illness onset?
☐ Yes ☐ No ☐Unknown

If yes,
a) What is relation? ______________________
b) Traced history of contact:

	Depart Date	**Return Date**	**Country**
1.	____/____/_______	____/____/_______	___________
2.	____/____/_______	____/____/_______	___________

10. Did patient have contact with a person with ARI in the 14 days prior to illness onset? ☐ Yes ☐ No ☐ Unknown

If yes, describe *(e.g., Case is sibling of a confirmed case)*

11. In the 14 days before onset did the patient have close contact with any of the following:
☐ Cows ☐ Bats ☐ Goats ☐ Camels ☐ Sheep
☐ Other animals, specify________________

Other risk factor(circle the relevant):
DM/ HTN/ Obesity/ pregnancy/ "immuno compromised"

12. Does patient work as a health care worker?
☐ Yes ☐ No ☐ Unknown
If Yes, health facility:______________________________

13. Diagnosis of pneumonia? ☐ Yes ☐ No ☐Unknown
If Yes: ☐ Clinical ☐ Radiographic ☐ Other
If other: ____________________________

14. Was the patient hospitalized in last month?
☐ Yes ☐ No ☐ Unknown
If yes:
a) Hospitalization Date: ____/____/_______
b) Discharge Date: ____/____/_______
c) Health facility: _________________________
d) Reason for admission: ________________________

15. Admitted to ICU
☐ Yes ☐ No ☐ Unknown

ICU Start Date: ____/____/_______

ICU Discharge Date: ____/____/_______

16. Mechanical Ventilation
☐ Yes ☐ No ☐ Unknown

If yes, Start Date: ____/____/_______

Duration (days): __________days

17. Acute Respiratory Distress Syndrome
☐ Yes ☐ No ☐ Unknown

18. Renal failure
☐ Yes ☐ No ☐ Unknown

19. Outcome
☐ Discharge, date: ____/____/_______
☐ Died, date: ____/____/_______

20. Respiratory Samples:

1. **BAL or Endotracheal aspirate** **Date of sample collection:** ____/____/_______ **Date sample sent:** ____/____/____
2. **Nasopharyngeal (NP) aspirates** **Date of sample collection:** ____/____/____ **Date sample sent:**___/____/_____
3. **Set of NP/ OP swabs in VTM** **Date of sample collection:** ____/____/_______ **Date sample sent:** __/____/_____
4. **Sputum in sterile container** **Date of sample collection:** ____/____/_______ **Date sample sent:** ___/____/_____

Additional Sample

Plasma in EDTA (5cc) **Date of sample collection:** ____/____/_______ **Date sample sent:** ____/____/_____

Doctor Signature:_______________________