



This is an official Oklahoma Health Alert

Network Health Advisory

The Oklahoma State Department of Health (OSDH) Acute Disease Service (ADS) is now using 4 types of documents to provide important information to medical and public health professionals, and to other interested persons:

Categories of Health Alert messages:

Health Alert

Provides vital, time-sensitive information for a specific incident or situation; warrants immediate action or attention by health officials, laboratorians, clinicians, and members of the public and conveys the highest level of importance.

Health Advisory

Provides important information for a specific incident or situation; contains recommendations or actionable items to be performed by public health officials, laboratorians, and/or clinicians; may not require immediate action.

Health Update

Provides updated information regarding an incident or situation; unlikely to require immediate attention.

Health Info/Event

Provides general public health information; unlikely to require immediate action.

March 18, 2020

OKHAN_306-2020_03-18 ADV-N

Reference: N/A

Update to Criteria to Guide Evaluation and Laboratory Testing for COVID-19

EFFECTIVE IMMEDIATELY: Due to a national shortage of test reagents and kits, specimens will only be approved for testing if:

the patient has fever¹ and symptoms of acute respiratory illness (e.g., cough, difficulty breathing)

AND EITHER

Hospitalized patients who have signs and symptoms compatible with COVID-19 in order to inform decisions related to infection control.

OR

Other symptomatic individuals such as, older adults and individuals with chronic medical conditions and/or an immunocompromised state that may put them at higher risk for poor outcomes (e.g., diabetes, heart disease, receiving immunosuppressive medications, chronic lung disease, chronic kidney disease).

OR

Any persons including healthcare personnel², who within 14 days of symptom onset had close contact³ with a suspect or laboratory-confirmed⁴ COVID-19 patient, or who have a history of travel from affected geographic areas within 14 days of their symptom onset.

All specimens submitted to the OSDH Public Health Laboratory for testing must be accompanied by the official *Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form* to ensure the testing criteria above are met. Specimens will be rejected if the PUI form is not submitted or the testing criteria are not met.

Clinicians are also encouraged to test for other causes of respiratory illness (e.g., influenza) prior to testing for COVID-19.

For patients who do not meet the priorities listed, clinicians should submit specimens to a commercial laboratory that provides SARS-CoV-2. Please, contact these commercial laboratories to find out the correct process for submission of specimens.

Guidance for testing at the PHL will be updated if laboratory supplies improve.

Summary Points

- Update to Criteria to Guide Evaluation and Laboratory Testing for COVID-19
- Scripted Guidance for Patient Evaluation
- CDC PUI and Case Report Form

Message #: OK-HAN_306 / Reference: N/A

Oklahoma State Department of Health / Acute Disease Service / 1000 NE 10th St, Oklahoma City, OK 73117
405-271-4060 (ph) / 405-271-6680 (fax) <http://ads.health.ok.gov>



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Mildly ill patients should be encouraged to stay home and contact their healthcare provider by phone for guidance about clinical management. Patients who have severe symptoms, such as difficulty breathing, should seek care immediately. Older patients and individuals who have underlying medical conditions or are immunocompromised should contact their physician early in the course of even mild illness. Provide patient with routine home care instructions for mild viral respiratory illness. Healthcare workers are encouraged to follow recommended infection control procedures.

It is not recommended to send patients to an ER for the sole purpose of specimen collection. This is an unnecessary risk of exposure to other patients and staff.

If healthcare provider staff do not currently receive the Oklahoma Health Alert Network (OK-HAN) notifications, please advise personnel to contact OKHAN@health.ok.gov for access or by calling the ADS and asking for the OK-HAN Coordinator.

References

- Oklahoma Acute Disease COVID-19 web page: <https://coronavirus.health.ok.gov/>
- <https://www.cdc.gov/coronavirus/2019-ncov/index.html>
- <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>.

This message has been distributed to Primary Care and Infectious Disease Physicians, Infection Preventionists, Laboratorians, Urgent Care Centers, Emergency Departments, and State and Local Health Officials



Oklahoma State Department of Health
Creating a State of Health

Screening Template for COVID-19 Testing at the OSDH Public Health Laboratory

Symptoms

- Does the patient have a fever above 100.4 and symptoms of acute respiratory illness? (e.g., cough, difficulty breathing)

☐ Yes

☐ No

Risk Factors

- ☐ Hospitalized patients who have signs and symptoms compatible with COVID-19 and other respiratory illnesses have been ruled-out in order to inform decisions related to infection control.
 - ☐ Other symptomatic individuals at higher risk for poor outcomes, including those who are ≥ 65 years, immunocompromised or have chronic medical conditions (e.g., diabetes, heart disease, receiving immunosuppressive medications, chronic lung disease, chronic kidney disease).
 - ☐ Suspected outbreak of COVID-19 among associated individuals with recent onset of similar fever and lower respiratory symptoms. Please, contact the OSDH Acute Disease Service at (405) 271-4060 to report suspected outbreaks.
 - ☐ Suspect COVID-19 in a patient associated with a high-risk exposure setting such as a long-term care facility.
 - ☐ Patients, including healthcare personnel, who within 14 days of symptom onset had close contact with a suspect or laboratory-confirmed COVID-19 patient.
- **Specimens for patients who do not meet the Symptom criteria AND at least one of the Risk Factor criteria above for testing will not be tested at the OSDH Public Health Laboratory. Clinicians should seek testing at a reference laboratory.**
 - Clinicians are strongly encouraged to test for other causes of respiratory illness (e.g., influenza).
 - Mildly ill (low grade fever, aches and pains, and dry cough) patients should be encouraged to stay home and contact their healthcare provider by phone for guidance about clinical management.

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

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

Patient Physical Address: _____ Patient Phone #: _____



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

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

Reporting jurisdiction: _____

Case state/local ID: _____

Reporting health department: _____

CDC 2019-nCoV ID: _____

Contact ID ^a: _____NNDSS loc. rec. ID/Case ID ^b: _____

a. Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case CA102034567 has contacts CA102034567 -01 and CA102034567 -02. ^bFor NNDSS reporters, use GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Last _____ First _____

Affiliation/Organization: _____ Telephone _____ Email _____

Basic information

What is the current status of this person? <input type="checkbox"/> PUI, testing pending* <input type="checkbox"/> PUI, tested negative* <input type="checkbox"/> Presumptive case (positive local test), confirmatory testing pending† <input type="checkbox"/> Presumptive case (positive local test), confirmatory tested negative† <input type="checkbox"/> Laboratory-confirmed case† *Testing performed by state, local, or CDC lab. †At this time, all confirmatory testing occurs at CDC Report date of PUI to CDC (MM/DD/YYYY): ____/____/____ Report date of case to CDC (MM/DD/YYYY): ____/____/____ County of residence: _____ State of residence: _____		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Not specified Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	Date of first positive specimen collection (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A Did the patient develop pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No Did the patient have acute respiratory distress syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No Did the patient have another diagnosis/etiology for their illness? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No Did the patient have an abnormal chest X-ray? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	Was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, admission date 1 ____/____/____ (MM/DD/YYYY) If yes, discharge date 1 ____/____/____ (MM/DD/YYYY) Was the patient admitted to an intensive care unit (ICU)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the patient receive mechanical ventilation (MV)/intubation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, total days with MV (days) _____ Did the patient receive ECMO? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the patient die as a result of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of death (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Unknown date of death
Race (check all that apply): <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____		Date of birth (MM/DD/YYYY): ____/____/____ Age: _____ Age units(yr/mo/day): _____		
Symptoms present during course of illness: <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Unknown	If symptomatic, onset date (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Unknown	If symptomatic, date of symptom resolution (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Still symptomatic <input type="checkbox"/> Unknown symptom status <input type="checkbox"/> Symptoms resolved, unknown date		
Is the patient a health care worker in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply): <input type="checkbox"/> Travel to a geographically affected area per CDC; https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html Specify site(s): _____ <input type="checkbox"/> Community contact with another lab-confirmed COVID-19 case-patient <input type="checkbox"/> Any healthcare contact with another lab-confirmed COVID-19 case-patient <input type="checkbox"/> Patient <input type="checkbox"/> Visitor <input type="checkbox"/> HCW <input type="checkbox"/> Animal exposure <input type="checkbox"/> Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown If the patient had contact with another COVID-19 case, was this person a U.S. case? Yes / No <input type="checkbox"/> Yes, nCoV ID of source case: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A				
Under what process was the PUI or case first identified? (check all that apply): <input type="checkbox"/> Clinical evaluation leading to PUI determination <input type="checkbox"/> Contact tracing of case patient <input type="checkbox"/> Routine surveillance <input type="checkbox"/> EpiX notification of travelers; if checked, DGMQID _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____				

CDC 2019-nCoV ID:

Form Approved: OMB: 0920-1011 Exp. 4/23/2020

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

Symptoms, clinical course, past medical history and social history

Collected from (check all that apply): ☐ Patient interview ☐ Medical record review

During this illness, did the patient experience any of the following symptoms?	Symptom Present?
Fever >100.4F (38C) ^c	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Subjective fever (felt feverish)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Muscle aches (myalgia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Runny nose (rhinorrhea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cough (new onset or worsening of chronic cough)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Shortness of breath (dyspnea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Nausea or vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Diarrhea (≥3 loose/looser than normal stools/24hr period)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Other, specify: _____	

Pre-existing medical conditions?

☐ Yes ☐ No ☐ Unknown

Chronic Lung Disease (asthma/emphysema/COPD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Diabetes Mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Cardiovascular disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Chronic Renal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Chronic Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Immunocompromised Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Neurologic/neurodevelopmental/intellectual disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	(If YES, specify) _____
Other chronic diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	(If YES, specify) _____
If female, currently pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Current smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Former smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Respiratory Diagnostic Testing

Test	Pos	Neg	Pend.	Not done
Influenza rapid Ag <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza PCR <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. metapneumovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parainfluenza (1-4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adenovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rhinovirus/enterovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronavirus (OC43, 229E, HKU1, NL63)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. pneumoniae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. pneumoniae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specimens for COVID-19 Testing

Specimen Type	Specimen ID	Date Collected	State Lab Tested	State Lab Result	Sent to CDC	CDC Lab Result
NP Swab			<input type="checkbox"/>		<input type="checkbox"/>	
OP Swab			<input type="checkbox"/>		<input type="checkbox"/>	
Sputum			<input type="checkbox"/>		<input type="checkbox"/>	
Other:			<input type="checkbox"/>		<input type="checkbox"/>	

SPECIFY LOCATION FOR SPECIMEN PICK UP:

Additional State/local Specimen IDs: _____