

## COVID-19 DAILY SYMPTOM MONITORING TOOL

Complete for contact of a confirmed Coronavirus disease 2019 (COVID-19) case

Details of <u>contact</u> of confirmed case (details of case completed just before instructions)				Details of health official completing this form		Date completing form	
NICD Identifier	Date of contact	DD/MM/YYYY	Place last contact	Surname	Name	DD/MM/YYYY	
Surname	Name			Role	Facility name		
Date of birth	DD/MM/YYYY	Age (Y)	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Email address	Telephone number		
Healthcare worker	Y <input type="checkbox"/> N <input type="checkbox"/>	If yes, facility name					
Contact number(s)	Email						
Physical address							
House number	Street		Suburb	Town			
District	Province		Patient traced	Y <input type="checkbox"/> N <input type="checkbox"/>			
Details of <u>confirmed</u> COVID-19 case							
Contact type <sup>1</sup>	Close <input type="checkbox"/> Casual <input type="checkbox"/>	Relation to case <sup>2</sup>		NICD identifier	Surname	DOB	DD/MM/YYYY

**Instructions for completion:** Mark “Y” if symptom present and “N” if not. If any symptoms are present collect, contact 082 883 9920 immediately and make immediate arrangements for the collection of a specimen. Refer to COVID-19 Quick Guide on the NICD website for additional details. Days post exposure to case.

DAY	1	2	3	4	5	6	7	8	9	10
Date (DD/MM)										
Measured body temp										
Fever (self-reported)	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Chills	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Cough	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Sore throat	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Shortness of breath	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Anosmia/Dysgeusia <sup>3</sup>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

<sup>1</sup> Close contact: A person having had face-to-face contact ( $\leq 1$  metre) or in a closed space with a COVID-19 case for at least 15 minutes while symptomatic or in the 2 days prior to symptom onset. This includes, amongst others, all persons living in the same household as a COVID-19 case and, people working closely in the same environment as a case. A healthcare worker or other person providing direct care for a COVID-19 case, while **not** wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, N95 respirator, eye protection). A contact in an aircraft sitting within two seats (in any direction) of the case, travel companions or persons providing care, and crew members serving in the section of the aircraft where the case was seated.

<sup>2</sup> Chose from: Spouse, Aunt, Child, Classmate, Colleague, Cousin, Father, Friend, Grandfather, Grandmother, Healthcare worker, Mother, Nephew, Niece, Other relative, Uncle. <sup>3</sup> Loss of sense of smell or altered sense of taste.