ANNEX: PIH COVID-19 Annex provides a space for job aids tools and quick references for staff to use in implementing a response to the COVID-19 pandemic. All documents here correspond directly to the Official PIH Guides and are organized accordingly. These will be frequently updated to correspond directly to the official guidelines.

Laboratory Procedures

1. Laboratory Procedure for COVID-19 IgM IgG RDT (SD Biosensor)
2. Laboratory Procedure for COVID-19 Fluorescent Antigen RDT (SD Biosensor)
3. FIND – Rapid Diagnostics Tests for COVID-19

Data Collection Tools

1. Digital Data Collection Tools
   a. CommCare
   b. OpenMRS
2. Printable Paper Forms
   a. Contact Tracing Community Based Care
   b. Intake Symptoms Screening Exposure and Outcomes
   c. Lab Orders and Test Results
   d. Facility Based Care

Cleaning and Disinfecting

1. Cleaning and Disinfecting Guidelines
2. Cleaning Clinical Spaces
3. Cleaning Non Clinical Spaces
4. COVID19 Transport guidelines
5. Acceptable Disinfectants
6. Liquid Chlorine Preparation

PPE Guidelines

1. PPE Conservation
2. PPE Conservation posters (English, French, Spanish)
3. PIH guide to extended use and reuse of masks and eye protection
4. Extended Use PPE – donning and doffing
5. PIH Covid Nonstandard PPE Memo

Facilities and Infrastructure

1. PHI BHI Covid Response
Laboratory Procedure for IgM/IgG RDT (SD Biosensor, STANDARD Q COVID-19 IgM/IgG Duo Test)

Standard operating procedure (SOP) for testing performed at laboratories and medical facilities by health care personnel.

Product description and principle
The STANDARD Q COVID-19 IgM/IgG Duo Test Kit is a rapid immunochromatography test designed for the qualitative presumptive detection of specific IgM and IgG to SARS-CoV-2 in humoral fluid (capillary whole blood, venous whole blood, serum, or plasma). Only 10µl of specimen is required for each antibody and the results are available within 15 minutes. No extra equipment is needed to perform the test, making this suitable for point-of-care (POC) testing.

Studies have shown that this test gives 81.8 % of sensitivity and 96.6 % of specificity.

Warnings and Precautions
- Wear PPE such as gown, gloves, surgical mask and face shield when collecting or performing the test. Refer to procedure for the proper use of PPEs.
- Clean work surface with available disinfectant before starting work.
- Place absorbent bench liner on work surface to capture potential splatters and splashes.
- Store test kits at 2-30°C / 36-86°F.
- Test kits have a shelf-life of 24 months.
- Use universal precautions when handling blood samples.
- Discard all materials used for sample collection and test procedures in a biohazard container and/or sharps bin.

Requirements and Sample Collection

Materials required but not provided:
- Proper PPE (for sample collection and test procedure)
- Permanent marker

For capillary whole blood samples:
- Lancet
- Alcohol wipes

For serum/plasma/venous whole blood:
- Venipuncture materials (tube with EDTA, heparin or sodium citrate, needle and/or syringe)
- Micropipette
- Sterile filtered tips for micropipette
- Centrifuge (for separating serum and plasma)

Materials provided:
- Capillary tube

Sample collection:
1. Blood by Fingerstick:
- Use the middle or ring finger, ideally of the non-dominant hand.
- Note: the puncture should be made slightly off center from the fleshy portion of the finger, near the side of the fingertip.
- Thoroughly disinfect the puncture site using an alcohol pad and let air-dry.
Stick the side of the finger with the lancet. Apply only light pressure to the fingertip, until a blood drop appears. Do not press or milk the finger.

Discard the lancet into a sharps bin.

Wipe away the first 2-3 drops of blood with the alcohol pad. Ensure there is a free blood flow.

Collect 10 µl blood with the capillary tube (refer to Test Procedure, below).

2. **Venous blood**: Collect blood using a tube with anticoagulant (EDTA, heparin, sodium citrate), as per instructions for phlebotomy.

### Test Procedure

**NOTE: it is recommended to do both the IgM and IgG tests simultaneously**

Materials required but not provided:
- Timer
- Permanent marker
- Proper PPE
- Micropipette (venous blood)
- Sterile filtered tips for micropipette (venous blood)

Materials provided:
- Capillary tube
- IgM test device
- IgG test device

1. Identify the sample ID number on both test devices (IgM and IgG).
2. Obtain 10 µl of sample using the provided capillary tube (up to the black line of the tube) if using blood taken by fingerstick. If using serum, plasma or anticoagulated blood, take 10 µl with a micropipette and corresponding tips.
3. Dispense 10 µl of specimen into the sample well of each test device (IgM and IgG).
4. Discard the capillary tube in a sharps bin.
5. Add 3 drops (90 µl) of buffer vertically into the buffer well of each test device.
6. Read test result at 10 to 15 minutes, but **not** after 15 minutes. It may give false results.
7. Record all results on the laboratory worksheet and report form.
8. Dispose of the test devices as biohazard materials.
9. Clean work surface with disinfectant at the end of the work.

### Interpretation of test result

There are two lines in the result window: one control line in the top (C) and one test line at the bottom (either M or G). Look for the presence or absence of colored bands on corresponding lines:

- **Negative Result for IgM**: In the test device for IgM, the band of the control line (C) is colored (dark or faint) and the band of the test line IgM (M) is not colored.
- **Negative Result for IgG**: In the test device for IgG, the band of the control line (C) is colored (dark or faint) and the band of the test line IgG (G) is not colored.
- **Positive Result for IgM**: The band of the control line (C) is colored (dark or faint) and the band of the test line IgM (M) is colored (uniform or not uniform).
• **Positive Result for IgG**: The band of the control line (C) is colored (dark or faint) and the band of the test line IgG (G) is colored (uniform or not uniform).

• **Invalid Result**: No colored band on line C. The band of the test line could be or not colored. Invalid result needs to be repeated with a new test device.
**Instructions for use**

**TEST PROCEDURE** - Be sure to test both STANDARD Q COVID-19 IgM and IgG simultaneously.

The test procedures for both COVID-19 IgM and IgG are the same.

**Using Capillary whole blood**

1. **Collecting of Specimen**
   - Using a capillary tube, collect the tip of capillary whole blood at the black line of the capillary tube.

2. **Adding of specimen**
   - Add the collected capillary whole blood to the specimen well of the test device.

3. **Dispensing of Buffer**
   - Add 3 drops of buffer vertically into the buffer well of the test device.

4. **Reading Time**
   - Read test result at 10-15 minutes.

**Using serum/plasma/venous whole blood**

1. **Collecting of Specimen**
   - Using a microtube, collect the tip of serum, plasma or venous whole blood with indelube.

2. **Adding of Specimen**
   - Add the collected serum, plasma or venous whole blood to the specimen well of the test device.

3. **Dispensing of Buffer**
   - Add 3 drops of buffer vertically into the buffer well of the test device.

4. **Reading Time**
   - Read test result at 10-15 minutes.

**INTERPRETATION OF TEST RESULT**

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
<th>Invalid</th>
</tr>
</thead>
</table>

1. A colored band will appear in the top section of the result window to show that the test is working properly. This band is control line (C).
2. A colored band will appear in the lower section of the result window. These bands are test line of IgM/IgG (M, G).
3. Even if the control line (C) is faint, or the test line (M, G) is uniform, the test should be considered to be performed properly and the test result should be interpreted as a positive result.
4. STANDARD Q COVID-19 IgM/IgG Duo Test may cross-react with anti-body against SARS-CoV-1.
5. Results from antibody testing should not be used as the sole basis to diagnose or exclude SARS-CoV-2 infection or to inform infection status.
6. Positive results should be considered in conjunction with the clinical history, RT-PCR results and other data available.

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STOP COVID Partners In Health

Updated 21 April 2020 | Annex Laboratory Procedures
**Internal Quality Control**

Each test device has a built-in control line (C). Appearance of a colored band (dark or faint) at the control line can be considered as an internal positive procedural control. A band at the control line will appear (dark or faint) if the test procedure has been correctly performed. If a band at the control line does not appear, the test is invalid and a new test must be performed.

If the problem persists, please contact your local vendor or SD BIOSENSOR.

**Limitation of Test**

1. The test procedure, precautions, and interpretation of results must be followed strictly.
2. STANDARD Q COVID-19 IgM/IgG Duo test may cross-react with antibodies against SARS-CoV-1.
3. Results from antibody testing should not be used as the sole basis to diagnose or exclude SARS-CoV-2 infection or to inform infection status.
4. Positive test results should be considered in conjunction with clinical history, RT-PCR results, and other data available.
5. For more accuracy of immune status, additional follow-up testing using other laboratory methods is recommended.
6. Neither the quantitative value nor the rate anti-SARS-CoV-2 IgM/IgG concentration can be determined by this qualitative test.
7. Failure to follow the test procedure and interpretation of test results may adversely affect test performance and/or produce invalid results.

**References:**

1. Instructions for using STANDARD Q COVID-19 IgM/IgG Duo Test,

2. PIH Guide to Community and Clinical Management of COVID-19,
Laboratory Procedure for the STANDARD™ F COVID-19 Ag FIA Test for Detection of SARS-CoV-2 antigen

*SOP for testing performed at laboratories and medical facilities by health care personnel*

**Product Description**

STANDARD F COVID-19 Ag FIA is a fluorescent immunoassay used for the qualitative detection of specific nucleoprotein antigens to COVID-19, in order to detect SARS-CoV-2 infection in the human nasopharynx.

**Note:** STANDARD F COVID-19 Ag FIA should be used with the STANDARD F Analyzers manufactured by SD BIOSENSOR. This test is for *in vitro* diagnostic use and intended as an aid to early diagnosis of COVID-19 infection in patients with clinical symptoms related to COVID-19 infection. This test provides only an initial screening test result. More specific alternative diagnosis methods should be performed in order to obtain the confirmation of COVID-19 infection.

**Test Principle**

STANDARD F COVID-19 Ag FIA test is based on immunofluorescence technology to detect the COVID-19 nucleoproteins. STANDARD F COVID-19 Ag FIA test has a test line coated with monoclonal anti-COVID-19 antibody. Test sample is applied into the specimen well of the test device, in which the specimen migrates through the membrane. If COVID-19 viral antigen is present in the test sample, it will react with conjugated monoclonal anti-COVID-19 antibody in the conjugation pad and form an antibody-antigen fluorescent particle complex. This complex moves along the membrane, to be captured by the anti-COVID-19 antibody on the test line and creates a fluorescent signal. The intensity of the fluorescent light generated on the membrane of the test is scanned by the STANDARD F Analyzer (manufactured by SD BIOSENSOR). The analyzer can then examine the presence of COVID-19 antigen from the clinical specimen by processing the results using pre-programmed algorithms and displaying the test result on the screen.

**Warnings and Precautions**

- Wear PPE such as gown, gloves, surgical mask, and face shield when collecting sample and/or performing the test. Refer to procedure for the proper use of PPEs.
- Observe biosafety measures and good laboratory practices when handling specimen or performing the test, such as:
  - Clean work surface with disinfectant available before starting work.
  - Place absorbent bench liner on work surface to capture potential splatters and splashes.
  - Clean up spills thoroughly using an appropriate disinfectant.
  - Handle all specimens as if they contain infectious agents.
  - Dispose of all specimens and test materials as bio-hazard waste.
  - Laboratory chemical and biohazard wastes must be handled and discarded in accordance with all local, state, and national regulations.
  - Clean the work bench and all non-disposable materials with disinfectant at the end of the work.
- Store the kit at room temperature or between 2-30°C / 36-86°F and out of direct sunlight.
- Kit materials are stable until the expiration date printed on the outer box.
• Do not freeze the kit.
• Do not re-use the test kit.
• Do not use the test kit if the pouch is damaged or the seal is broken.
• Do not use extraction buffer from another lot.
• Use the STANDARD F COVID-19 Ag FIA at 15-32°C / 59-90°F and 10-90% RH (relative humidity).
• Observe established precautions against microbiological hazards throughout all testing procedures.
• Desiccant in foil pouch is used to absorb moisture and keep humidity from affecting products. If desiccant beads change from yellow to green (indicating moisture present), the test device in the pouch should be discarded.
• Immediately use the test device after taking out of aluminum foil pouch.
• As the detection reagent is a fluorescent compound, no visible results will form on the test device to the naked eye.
• The barcode of the test device is used by the STANDARD F Analyzer to identify the type of test being run and to identify the individual test device in order to prevent a second read by the same analyzer.
• Once a test device has been successfully scanned by the STANDARD F Analyzer, do not attempt to scan the test device again in the same analyzer.
• Improper specimen collection, handling, or transport may yield inaccurate results.
• Do not write on the barcode or damage the barcode of the test device.

Sample Collection and Requirements:

Materials required but not provided:
- Proper PPE
- Sterile closed container or tube
- Permanent marker

Materials provided:
- Sterile nasopharyngeal swab

Sample Collection

Nasopharyngeal swab
1. Confirm that the sample ID number matches patient name (or other unique identifier).
2. Seat the patient comfortably.
3. Tilt the head back and insert the sterile swab into the nostril that presents the most secretion under visual inspection.
4. Using gentle rotation, insert sterile swab parallel to the floor of nose without pointing upwards until resistance is felt at the level of the turbinate.
5. Rotate the sterile swab a few times against the nasopharyngeal wall.
6. Remove the sterile swab from the nostril, carefully.
7. Specimen should be tested as soon as possible after collection.
8. Specimen should be labeled with sample number and collection date, and may be stored at room temperature for up to 24 hours, or at 2-8°C / 36-46°F for up to 48 hours in a clean, dry, closed container prior to testing.
Caution: do not use a viral transport medium for specimen storage. It may cause inaccurate result.

Test Procedure

Materials required but not provided:
- STANDARD F Analyzer (SD Biosensor)
- Timer
- Permanent marker
- Proper PPE

Materials provided:
- Test device (individually packed in a foil pouch with desiccant)
- Extraction buffer tube
- Filter cap for extraction tube

Preparation of test device and specimen
1. Allow specimen and test device (if test is not performed immediately after collection) to room temperature (15-32°C / 59-86°F).
2. Check the expiration date at the back of the foil pouch. Do not use an expired kit.
3. Check the test device and the desiccant beads for indication of moisture.
4. Check the time and date of collection of the specimen. Test should be performed:
   a. Within 24 hours of collection, if stored at room temperature.
   b. Within 48 hours of collection, if stored at 2-8°C / 36-46°F.
5. If a violet colored band (the check band) does not appear in the result window of the test device, do not use it.
6. Note: do not write on the barcode or damage the barcode of the test device.

Extraction of specimen
1. Label extraction buffer tube with sample ID number in permanent marker.
2. Insert nasopharyngeal swab into an extraction buffer tube and swirl the swab at least 5 times.
3. Remove the swab vertically while squeezing the sides of the tube to extract the liquid from the swab.
4. Tightly screw the filter cap onto the tube – this is now your mixed sample.

Analysis of the specimen

Note: please reference “Quick Guide for F200” and/or “Quick Guide for F2400” to assist you using the Standard F Analyzer. However, these guides do not serve as a substitute for thorough reading of the instruction manual.

- Option A: ‘STANDARD TEST’ mode
  STANDARD F200, F2400

1. Prepare STANDARD F Analyzer:
Select the ‘Standard Test’ mode according to the analyzer’s manual.
  o STANDARD F2400 analyzer:
    ▪ Go to the ‘Workplace’ in the main screen.
    ▪ Select the ‘Run Test’.
    ▪ Enter patient ID and/or operator ID on the analyzer.
  o STANDARD F200 analyzer:
    ▪ Enter patient ID and/or operator ID on the analyzer.

2. Insert the test device into the test slot of the analyzer. The analyzer will read the barcode data and check if the test device is valid.
3. Ensure the filter cap is screwed on tightly to extraction tube. Apply 4 drops of mixed sample to the specimen well in the test device.
4. After applying the sample, immediately press the ‘TEST START’ button on the analyzer.
5. The analyzer will automatically display the test result in 30 minutes.
6. Record results on the laboratory worksheet and report form.
7. Dispose the test devices and extraction tubes as biohazard materials.
8. Clean work surface with disinfectant at the end of the work.

❖ Option B: ‘READ ONLY’ mode

STANDARD F200
1. Label the test device with the corresponding sample ID number written on the extraction tube.
2. Ensure the filter cap is screwed on tightly to extraction tube. Apply 4 drops of mixed sample to the specimen well in the test device.
3. Set the test device on the work bench at room temperature for 30 minutes.
4. Prepare the STANDARD F Analyzer F200 and select the ‘Read Only’ mode according to the analyzer’s manual.
5. Insert the test device to the test slot of the analyzer.
6. After inserting the test device to the analyzer, the analyzer will automatically scan and display the test result.
7. Record results on the laboratory worksheet and report form.
8. Dispose the test devices and pipettes as biohazard materials.
9. Clean work surface with disinfectant at the end of the work.

### Interpretation of Test Results

<table>
<thead>
<tr>
<th>Result</th>
<th>COI (Cutoff index) value</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>COI ≥ 1.0</td>
<td>Positive for COVID-19 Ag</td>
</tr>
<tr>
<td>Negative</td>
<td>COI &lt; 1.0</td>
<td>Negative for COVID-19 Ag</td>
</tr>
<tr>
<td>Invalid</td>
<td>COI value is not displayed</td>
<td>Repeat test. A new test device and a new patient specimen should be collected and used for repeated test.</td>
</tr>
</tbody>
</table>

**NOTE:**
- The test result of a specimen is given either as Positive(+)/Pos(+) or Negative(-)/Neg(-) with a COI (cut off index) value. The COI is a numerical representation of the measured fluorescence signal.
- Positive results should be considered in conjunction with the clinical history and other data available to the physician.
• In case of discrepancy test result, additional follow-up testing using other laboratory methods is recommended.

Quality Control

STANDARD F Analyzers – calibration check

The calibration set test of STANDARD F Analyzers should be conducted according to the analyzer’s manual.

When to use calibration set:
1. Before using the analyzer for the first time.
2. If you drop the analyzer.
3. Whenever you do not agree with your result.
4. When you want to check the performance of an analyzer and test device.

How to use calibration set:
Calibration set test is a required function that ensures optimal performance by checking the internal analyzer optics and functions.
1. Select the ‘Calibration’ menu.
2. The specific calibration set is included with the analyzer.
3. Insert the CAL-1 first, and then insert the CAL-2 for UV-LED testing, and the CAL-3 for RGB-LED testing in order.

Internal procedural control:
1. The “internal procedural control zone” is in the end of the membrane of the test device. STANDARD F Analyzers read the fluorescence signal of the internal procedural control zone and determine whether the result is valid or invalid.
2. An invalid result denotes that the fluorescence signal is not within the pre-set range. If the screen of STANDARD F analyzer shows ‘Invalid Device’, turn off and turn on the analyzer again and re-test with a new test device.

External quality control:
1. Positive and negative controls may be supplied with each kits or can be purchased from the distributors.
2. It is recommended that positive and negative controls be run:
   • Once for each new lot.
   • Once for each untrained operator.
   • As required by test procedures in these instructions and in accordance with local, state, and federal regulations or accreditation requirements.

Limitation of Test
1. The test procedure, precautions, and interpretation of results for this test must be followed strictly when testing.
2. This test detects the presence of COVID-19 in the sample specimen and should not be used as the sole criteria for the diagnosis of COVID-19 infection.
3. Test results must be considered with other clinical data available to the physician.
4. For more accuracy of immune status, additional follow-up testing using other laboratory methods is recommended.
5. Neither the quantitative value nor the rate of COVID-19 concentration can be determined by this qualitative test.
6. Failure to follow the test procedure and interpretation of test results may adversely affect test performance and/or produce invalid results.

References:
1. Instructions for using STANDARD F COVID-19 Ag FIA Test  
   http:sdbiosensor.com/xe/product/7662
2. PIH Guide to Community and Clinical Management of COVID-19,  
RAPID DIAGNOSTIC TESTS FOR COVID-19

RAPID DIAGNOSTIC TESTS (RDTs) CAN DETECT EITHER ANTIGEN (Ag) OR ANTIBODY (Ab), AND BOTH TEST TYPES HAVE IMPORTANT ROLES GIVEN THE CURRENT EPIDEMIC CONTEXT (COMMUNITY TRANSMISSION)

A combination of different test types is needed to facilitate patient management and public health planning for effective control of COVID-19. Tests that directly detect the virus (polymerase chain reaction [PCR] or Ag) should be prioritized for diagnosis and monitoring; while tests that detect the immune response to the virus (Ab), can be complementary for clinical care, but should be prioritized for seroprevalence and epidemiological purposes. Importantly, the utility of any test is dependent on several factors: 1) the test performance (i.e. sensitivity and specificity), 2) the epidemiological context in which it is used (i.e. the disease prevalence), and 3) the timing of test use in relation to disease kinetics (especially true for Ab tests). (See page 4 for more details.)

GENERAL INFORMATION ON Ag- AND Ab-DETECTION RDTs FOR COVID-19

• RDTs can enable fast (15–40 minutes), decentralized access to testing, but generally have decreased performance compared with lab-based tests:
  • Tests with the highest possible sensitivity must be prioritized to minimize false negatives, as these may lead to missing cases.
  • High specificity is also important, particularly as prevalence decreases.

• Ag tests directly detect SARS-CoV-2 virus, will be positive within a few days after infection, and will become negative as the patient clears the infection and recovers. Therefore, Ag tests are useful for detection of active infection.

• Ab tests detect the host response to the virus and take several more days to become positive – they are likely to be most accurate 10–14 days post infection. Ab tests cannot distinguish between active and previous infection. Current data are limited on the correlation between antibody detection and immunity/protection.

• Positive results from either Ag or Ab tests, together with the presence of respiratory symptoms, indicate that an individual is likely to be actively infected with SARS-CoV-2 (dependent on the positive predictive value of the test). Without waiting for confirmatory testing, the individual should undergo home isolation, or healthcare facility admission if symptoms require advanced care.
  • In individuals without symptoms and no known contact with a person suspected to have COVID-19 in the past 14 days, a positive Ab test followed by a negative PCR test indicates prior infection.

• Negative results from either Ag or Ab tests should be interpreted with caution (dependent on the negative predictive value of the test). For suspect cases with negative results, consider accessing a more sensitive test for confirmation (i.e. PCR), and/or home isolation followed by a second test at a later date.

SUGGESTED USES FOR Ag- AND Ab-DETECTION RDTs GIVEN OUR CURRENT UNDERSTANDING

• Ag RDTs should be prioritized for case management to enable decentralized testing, especially when access to PCR testing is limited.

• Ab RDTs should be prioritized for seroprevalence surveys to inform public health measures and testing of contacts to establish previous spread of the virus.

<table>
<thead>
<tr>
<th>Suggested use</th>
<th>Ag</th>
<th>Ab</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triage suspect cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive: no confirmatory testing required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative: confirmatory testing with PCR recommended, if available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aid diagnosis in symptomatic cases presenting late (≥10 days post-symptom onset)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In addition to PCR/Ag, not a replacement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor active infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screen contacts for infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screen contacts for previous exposure (≥10 days post exposure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seroprevalence surveys to define levels of population exposure,* including vaccine trial support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Insufficient data supporting effectiveness of protection or duration of immunity.
• SARS-CoV-2 is a respiratory pathogen, unlike malaria, HIV, dengue, Zika or chikungunya viruses.

• The immune response to SARS-CoV-2 may be atypical:
  • Other viruses: IgM is detectable in the blood during active infection and then wanes after a few weeks, whereas IgG levels rise after the acute phase.
  • SARS-CoV-2: Preliminary studies suggest that IgM and IgG rise during early infection and may remain high for weeks, though more data are needed.

• Respiratory specimens may contain high levels of virus days before the onset of symptoms, even in individuals who remain asymptomatic.

• In a pandemic situation, where there are no specific treatments and the goal is to minimize spread of the infection by breaking the chain of transmission, tests with the highest possible sensitivity must be selected to minimize the possibility of missing any active cases:
  • To reduce the burden on confirmatory testing in high prevalence settings, a positive result from a screening test (even with low specificity and thus a higher probability of false positivity) may not require confirmation.
  • In this scenario, all individuals who screen positive should undergo home isolation, or be admitted to a healthcare facility if symptoms are severe and warrant hospitalization.

### UNIQUE FEATURES OF SARS-COV-2 THAT ARE IMPORTANT TO CONSIDER WHEN USING RDTs

<table>
<thead>
<tr>
<th>OPERATIONAL CHARACTERISTICS AND OVERVIEW</th>
<th>Antibody (Ab) (IgA, IgM and/or IgG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does it work?</td>
<td>Detects the body’s immune response to the virus, in the form of antibodies (IgA, IgM, IgG or in combination), which are produced during active infection, but also persist after the virus is no longer detected, indicating previous infection</td>
</tr>
<tr>
<td>Sample type</td>
<td>Fingertip blood, venous blood; potentially oral fluid</td>
</tr>
<tr>
<td>Where and who performs?</td>
<td>Trained healthcare workers, wearing appropriate personal protective equipment (PPE) at decentralized points of need</td>
</tr>
<tr>
<td>Benefits</td>
<td>Best biomarker for estimation of the number of people previously infected: enables more accurate estimates of case fatality rates, serial sampling can be used to estimate incidence</td>
</tr>
<tr>
<td></td>
<td>In high prevalence settings, may be useful to triage symptomatic patients in a later phase of disease and reduce the burden on the laboratory testing system (relieve bottlenecks): positive results can trigger clinical action; negative results should reflex to PCR for confirmatory testing, if available</td>
</tr>
<tr>
<td></td>
<td>In low prevalence settings, the use of Ab tests to triage symptomatic patients is unlikely to be beneficial due to low PPV</td>
</tr>
</tbody>
</table>
**TEST UTILITY IS RELATED TO THE TEST PERFORMANCE (SENSITIVITY/SPECIFICITY) AS WELL AS THE EPIDEMIC SETTING (i.e. PREVALENCE IN THE POPULATION)**

The number of true positives and true negatives is dependent on the prevalence of the population being tested, as illustrated in the table on the next page.

<table>
<thead>
<tr>
<th>INTERPRETATION OF TEST RESULTS</th>
<th>Antigen (Ag)</th>
<th>Antibody (Ab) (IgA, IgM and/or IgG)</th>
</tr>
</thead>
</table>
| **A true positive result...** | Means SARS-CoV-2 is present; the person is actively infected and should home isolate or be admitted to a healthcare facility  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised | Indicates an active or past infection  
olicy should be considered and testing for other respiratory pathogens is advised  
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olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  |
| **A true negative result...** | Indicates an active or past infection  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised | Indicates an active or past infection  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised |  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  |
| **A false positive result...** | Means that the person is infected, but is missed  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised | Means that the person is infected, but is missed  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised |  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  |
| **A false negative result...** | Means that the person is infected, but is missed  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised | Means that the person is infected, but is missed  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised |  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  
olicy should be considered and testing for other respiratory pathogens is advised  |

* Insufficient data supporting effectiveness of protection or duration of immunity.

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Tests with poor specificity/high cross-reactivity could be falsely reactive due to other endemic infections.
As seen below, a test with high performance (95% sensitivity and 98% specificity), when applied to a low-prevalence setting, will result in roughly the same number of true positives and false positives (PPV: ~50%), whereas when applied to a higher prevalence population would result in a much higher positive predictive value (PPV: 95%), with the majority of positive results associated with actual cases. Alternatively, the use of a mid-or lower-performing test might be considered for a high prevalence population (PPV: 68-78%), but would lead to such high numbers of false positives when testing a low prevalence population that this would likely do more harm than good. Across a range of sensitivities and prevalence, the negative predictive value remains relatively high, but the consequence of missed cases for epidemic control and case management can be detrimental.

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Pre-test probability (prevalence)</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Cases</th>
<th>Non-cases</th>
<th>True positive (TP)</th>
<th>False negative (FN)</th>
<th>True negative (TN)</th>
<th>False positive (FP)</th>
<th>PPV</th>
<th>NPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>High performance</td>
<td>1,000</td>
<td>2.0%</td>
<td>95%</td>
<td>98%</td>
<td>20</td>
<td>980</td>
<td>19</td>
<td>1</td>
<td>960</td>
<td>20</td>
<td>49.2%</td>
</tr>
<tr>
<td></td>
<td>1,000</td>
<td>5.0%</td>
<td>95%</td>
<td>98%</td>
<td>50</td>
<td>950</td>
<td>48</td>
<td>2</td>
<td>931</td>
<td>19</td>
<td>71.4%</td>
</tr>
<tr>
<td></td>
<td>1,000</td>
<td>10.0%</td>
<td>95%</td>
<td>98%</td>
<td>100</td>
<td>900</td>
<td>95</td>
<td>5</td>
<td>882</td>
<td>18</td>
<td>84.1%</td>
</tr>
<tr>
<td></td>
<td>1,000</td>
<td>30.0%</td>
<td>95%</td>
<td>98%</td>
<td>300</td>
<td>700</td>
<td>285</td>
<td>15</td>
<td>686</td>
<td>14</td>
<td>95%</td>
</tr>
<tr>
<td>Mid performance</td>
<td>1,000</td>
<td>2.0%</td>
<td>85%</td>
<td>90%</td>
<td>20</td>
<td>980</td>
<td>17</td>
<td>3</td>
<td>882</td>
<td>98</td>
<td>14.8%</td>
</tr>
<tr>
<td></td>
<td>1,000</td>
<td>5.0%</td>
<td>85%</td>
<td>90%</td>
<td>50</td>
<td>950</td>
<td>43</td>
<td>8</td>
<td>855</td>
<td>95</td>
<td>30.9%</td>
</tr>
<tr>
<td></td>
<td>1,000</td>
<td>10.0%</td>
<td>85%</td>
<td>90%</td>
<td>100</td>
<td>900</td>
<td>85</td>
<td>15</td>
<td>810</td>
<td>90</td>
<td>48.6%</td>
</tr>
<tr>
<td></td>
<td>1,000</td>
<td>30.0%</td>
<td>85%</td>
<td>90%</td>
<td>300</td>
<td>700</td>
<td>255</td>
<td>45</td>
<td>630</td>
<td>70</td>
<td>78%</td>
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<tr>
<td>Low performance</td>
<td>1,000</td>
<td>2.0%</td>
<td>75%</td>
<td>85%</td>
<td>20</td>
<td>980</td>
<td>15</td>
<td>5</td>
<td>833</td>
<td>147</td>
<td>9.3%</td>
</tr>
<tr>
<td></td>
<td>1,000</td>
<td>5.0%</td>
<td>75%</td>
<td>85%</td>
<td>50</td>
<td>950</td>
<td>38</td>
<td>13</td>
<td>808</td>
<td>143</td>
<td>20.8%</td>
</tr>
<tr>
<td></td>
<td>1,000</td>
<td>10.0%</td>
<td>75%</td>
<td>85%</td>
<td>100</td>
<td>900</td>
<td>75</td>
<td>25</td>
<td>765</td>
<td>135</td>
<td>35.7%</td>
</tr>
<tr>
<td></td>
<td>1,000</td>
<td>30.0%</td>
<td>75%</td>
<td>85%</td>
<td>300</td>
<td>700</td>
<td>225</td>
<td>75</td>
<td>595</td>
<td>105</td>
<td>68%</td>
</tr>
</tbody>
</table>

The expected prevalence of active or previous COVID-19 infection will vary across populations being tested and is therefore an important consideration when selecting tests and interpreting results. Example prevalence ranges for some target populations are summarized below.

<table>
<thead>
<tr>
<th>Target population</th>
<th>Example prevalence range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic healthcare workers</td>
<td>High to very high (10 – ≥ 30%)</td>
</tr>
<tr>
<td>Healthcare workers with significant exposure</td>
<td>High (10%)</td>
</tr>
<tr>
<td>Contacts of index patient</td>
<td>Low to high (2 – 10%)</td>
</tr>
<tr>
<td>Community testing/contact tracing of hotspots</td>
<td>Medium to high (5 – ≥ 10%)</td>
</tr>
<tr>
<td>Symptomatic general population</td>
<td>Low (2%)</td>
</tr>
<tr>
<td>Asymptomatic general population</td>
<td>Very low to low (≤ 2%)</td>
</tr>
</tbody>
</table>
Quick Guide for Interpretation of Diagnostic Tests for SARS-CoV-2

Compiled by: PIH Laboratory Services
V1.0, June 2020

Purpose: to serve as a reference tool for clinicians, nurses, lab technicians, and medical auxiliaries to aid in the understanding and interpretation of the rapid diagnostic tests (RDTs) and RT-PCR.

Section 1. Testing for SARS-CoV-2
Below is a brief summary of three tests for SARS-CoV-2: reverse transcription (RT)-PCR, Ab RDT, and Ag RDT.

TABLE 1: Types of Diagnostic Tests and Comparison of Key Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>RT-PCR</th>
<th>Antibody (IgM/IgG) RDT</th>
<th>Antigen (Ag) rapid RDT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>Viral RNA</td>
<td>Host immune response: production of IgM and IgG antibodies</td>
<td>Viral protein: nucleocapsid protein</td>
</tr>
<tr>
<td>Sample</td>
<td>Nasopharyngeal swab, oral swab or sputum</td>
<td>Blood (finger stick or blood draw)</td>
<td>Nasopharyngeal swab</td>
</tr>
<tr>
<td>Acceptable time for sample collection (see Figure 1)</td>
<td>Acute phase of infection (1-21 days after symptom onset)</td>
<td>7-10 days after symptoms onset.</td>
<td>Acute phase of infection (1-14 days after symptom onset)</td>
</tr>
<tr>
<td></td>
<td>A few days before the onset of symptoms, the viral load may be low and virus cannot be detected.</td>
<td>As such, Ab testing should not be utilized to screen asymptomatic persons for active infection.</td>
<td>A few days before the onset of symptoms, the viral load may be low and virus cannot be detected.</td>
</tr>
<tr>
<td>False positives</td>
<td>Almost none</td>
<td>Low to moderate</td>
<td>Very low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cross-reactivity with other coronaviridae can occur.</td>
<td></td>
</tr>
<tr>
<td>False negatives</td>
<td>Low to moderate</td>
<td>Variable</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>Especially if sample taken before symptom onset or as a patient is starting to clear infection and viral load is decreasing. Can also be due to unideal time of sample collection or deficiency in sampling technique.</td>
<td>High during first week of symptoms (known as the &quot;window period&quot; when Ab concentration is low because the body has not yet produced them).</td>
<td>Not as sensitive as RT-PCR; same limitations of RT-PCR.</td>
</tr>
<tr>
<td>Turn-around time</td>
<td>Hours to 1-2 days (more if test transported to off-site lab)</td>
<td>10-15 minutes</td>
<td>15-30 minutes</td>
</tr>
<tr>
<td>Personnel and Laboratory requirements</td>
<td>High - previous experience with molecular technique recommended. Laboratory with high technical capacity required.</td>
<td>Low- no laboratory required.</td>
<td>Low- no laboratory required.</td>
</tr>
</tbody>
</table>

Estimated time intervals and rates of viral detection are based on data from several published reports. Because of variability in values among studies, estimated time intervals should be considered approximations and the probability of detection of SARS-CoV-2 infection is presented qualitatively. Most of the available data are for adult populations who are not immunocompromised. The time course of RT-PCR positivity and seroconversion may vary in children and other groups.

Section 2. Performance and Diagnostic Accuracy of the RDTs from SD Biosensor

PIH has purchased two RDTs from the Korean company, SD Biosensor:

**Antibody test → STANDARD Q COVID-19 IgM/IgG Combo Test**
- Used for the detection of SARS CoV-2 antibodies: IgM and IgG.
- False positive results may occur due to cross-reactivity from pre-existing antibodies, infection with SARS-CoV (etiologic agent of the Severe Acute Respiratory Syndrome, SARS, epidemic from 2002), or other possible causes.

**Antigen test → STANDARD Q COVID-19 Ag Test, lateral flow assay (LFA)**
- Used for the identification of SARS-CoV-2 nucleocapsid antigen from human nasopharyngeal swab specimens.
Positive results indicate the presence of viral antigens, but clinical correlation with patient history and other diagnostic information is necessary to determine infection status.

For both tests:
- Negative results from these tests do not rule out SARS-CoV-2 infection and should not be used as the sole basis for treatment or patient management decisions, including infection control decisions.
- Negative results should be considered in the context of a patient’s recent exposures, history and the presence of clinical signs and symptoms consistent with COVID-19, and confirmed with a molecular assay, if necessary, for patient management.

**TABLE 2: SD Biosensor STANDARD Q COVID-19 IgM/IgG Combo Test - Clinical Evaluation**

<table>
<thead>
<tr>
<th>From symptom onset:</th>
<th>Sensitivity*</th>
<th>Specificity*</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 7 days</td>
<td>94.48% (154/163)</td>
<td>95.74% (225/235)</td>
</tr>
<tr>
<td>&lt; 7 days</td>
<td>75% (30/40)</td>
<td></td>
</tr>
<tr>
<td>7-14 days</td>
<td>89.23% (58/65)</td>
<td></td>
</tr>
<tr>
<td>&gt;14 days</td>
<td>96.94% (95/98)</td>
<td></td>
</tr>
</tbody>
</table>

* Compared to RT-PCR
** Pooled data from:
1) Korea; April 2020; 30 COVID-19 positive and 75 COVID-19 negative sera specimens
2) Korea; April 2020; 176 COVID-19 positive and 160 COVID-19 negative sera specimens

**TABLE 3: SD Biosensor STANDARD Q COVID-19 Ag Test - Clinical Evaluation**

<table>
<thead>
<tr>
<th>STANDARD Q COVID-19 Ag Test (LFA)</th>
<th>Clinical Report #1</th>
<th>Clinical Report #2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country</td>
<td>Malaysia</td>
<td>Korea</td>
</tr>
<tr>
<td>Type of Samples</td>
<td>Nasopharyngeal swabs collected and stored in VTM</td>
<td>Nasopharyngeal swabs collected and stored in VTM</td>
</tr>
<tr>
<td>Number of patients</td>
<td>40 (32 positive, 8 negative)</td>
<td>125 (65 positive, 60 negative)</td>
</tr>
<tr>
<td>Sensitivity*</td>
<td>84.4%</td>
<td>89.23%</td>
</tr>
<tr>
<td>Specificity*</td>
<td>100%</td>
<td>96.67%</td>
</tr>
</tbody>
</table>

* Compared to RT-PCR
COVID-19 Data Collection Tools Overview

Digital Data Collection Tools

1. Screening, Intake, and Contact Tracing in CommCare
   Click here to view the COVID-19 CommCare Mobile Data Collection Application help documentation and demo videos. The application is available in each site’s CommCare project space to be viewed. Please email BostonSIS@pih.org for further demonstrations and support on this application. This application is available in French and English.

2. COVID-19 Inpatient Care in OpenMRS EMR
   Click here to view the COVID-19 OpenMRS module help documentation and demo videos. Please email BostonSIS@pih.org for further demonstrations and support implementing these modules. This module is available in French and English.

Printable Paper Forms

Printable forms are provided below and in the PIH COVID 19 Sharepoint folder. There are editable versions of each of these forms in Sharepoint so that sites can tailor them to their specific contexts.

Note: Click on the form areas below to be taken to form descriptions and the following printables:

1. Contact Tracing and Community-based Care
   A. Contact Tracing and Isolation Monitoring Register
   B. Case Monitoring in Community Register
   C. Suspected Case Testing Follow-Up Register

2. Intake, Symptoms Screening, Exposure, and Outcomes
   A. Intake and Symptom Screening for Cases or Contacts
   B. Exposure and Final Outcomes for Cases or Contacts

3. Lab Orders and Test Results
   A. Rapid Test Request and Result Form
   B. Lab Register

4. Facility-based care
   A. Facility Patient Register
   B. Facility Admission Form
   C. Facility Daily Progress Form
   D. Facility Discharge Form
Digital Data Collection Tools

CommCare Mobile Data Collection Application: Documentation and Demo Video for Contact Tracing and Suspect Follow-up Application

The following links will take you to documentation providing an overview of the application’s functionality, and to a demo video which will walk you through the application.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Links</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Overview Documentation</td>
<td>Click Here</td>
</tr>
<tr>
<td>Stream Demo Video</td>
<td>Click Here</td>
</tr>
<tr>
<td>Download Demo Video</td>
<td>Click Here</td>
</tr>
</tbody>
</table>

OpenMRS Electronic Medical Record System: COVID-19 Inpatient Care Modules

The following links will take you to documentation providing an overview of the OpenMRS module’s functionality, and to a demo video which will walk you through the module.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Links</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 Inpatient Care Module Overview</td>
<td>Click Here</td>
</tr>
<tr>
<td>COVID-19 Lab Ordering and Results Entry Overview</td>
<td>Click Here</td>
</tr>
<tr>
<td>COVID-19 Patient Admission Demo Video</td>
<td>Click Here</td>
</tr>
</tbody>
</table>
Printable Paper Forms

1. Contact Tracing and Community Monitoring Registers
Find editable versions [here](#).

A. Contact Tracing and Isolation Monitoring Register

| What | A register to collect a COVID-19 case’s recent contacts. This register allows any contact tracer to find and screen contacts. The register also allows contact tracer to follow up with contacts to monitor for symptom development, refer for testing, and close out contact record at the end of isolation period or upon conversion to a case. |
| Where | List of contacts can be filled in facility if case is admitted or in community if case is at home/isolation facility. Contact follow up happens in community wherever contact is. |
| Who | Contact Tracer |
| When | When a COVID-19 case gives a list of their contacts, then it is maintained at any follow up with contacts |

B. Case Monitoring in Community Register

| What | A register or patients who are positive but have mild symptoms and are isolating at home/isolation facility. Health workers will need to monitor these people for worsening symptoms and support home-based care. |
| Where | Community, either at home or an isolation facility where the case is. |
| Who | Any care team member following up with community-based cases of COVID-19 |
| When | A new person is added to a team member’s list when they become responsible for monitoring a case in the community. |

C. Suspected Case Testing Follow-Up Register

| What | A register for people who are still waiting for confirmatory testing and may not be COVID-19 cases despite symptoms or exposure. Suspected cases move off this list quickly when their diagnosis is presumed, confirmed or ruled-out at the end of the isolation time period. |
| Where | First filled at the laboratory where patient receives first rapid test. Intended for tracking at community level, but could be adapted for follow up of admitted patients who are also awaiting confirmatory test results. |
| Who | Community care team member who is assigned to follow up with patients who need confirmatory testing |
| When | When a symptomatic person requires confirmatory testing to determine diagnosis. Suspect is assigned to a community care team member, and moved from the list when it is determined that patient will be isolating in community, or admitted to facility, or is not a COVID-19 case. |
# COVID-19 Contact Tracing and Isolation Follow Up List

<table>
<thead>
<tr>
<th>Line No.</th>
<th>Assigned Contact ID</th>
<th>Name of Contact</th>
<th>Address of Contact (Town/Village and Landmarks)</th>
<th>Age</th>
<th>Sex</th>
<th>Date of Last Contact with Case (DD/MM/YY)</th>
<th>Scheduled Date of Isolation End (DD/MM/YY)</th>
<th>Date Symptoms Develop (DD/MM/YY)</th>
<th>Referred for testing and results</th>
<th>Assigned Case ID</th>
<th>Final Outcome²</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>□ refer □ + □ -</td>
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<td>2</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
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<td>6</td>
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<tr>
<td>7</td>
<td></td>
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<td>8</td>
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<td>/ /</td>
<td>□ refer □ + □ -</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1Received on positive test result or presumed positive.

²NS=Never had symptoms REC=recovered RF=refuse D=died L=Lost A=admitted

Form Version 4
20-Apr-20
<table>
<thead>
<tr>
<th>Line Number</th>
<th>Case Name</th>
<th>Address of contact</th>
<th>Sex</th>
<th>Date of Symptom Onset (DD/MM/YY)</th>
<th>Date of Scheduled Isolation End (DD/MM/YY)</th>
<th>Develop Severe Symptoms?</th>
<th>Still symptomatic at end of Isolation?</th>
<th>Refer to health facility?</th>
<th>Final Outcome&lt;sup&gt;1&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ severe</td>
<td>□ still symptom</td>
<td>□ refer</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ severe</td>
<td>□ still symptom</td>
<td>□ refer</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ severe</td>
<td>□ still symptom</td>
<td>□ refer</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ severe</td>
<td>□ still symptom</td>
<td>□ refer</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ severe</td>
<td>□ still symptom</td>
<td>□ refer</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ severe</td>
<td>□ still symptom</td>
<td>□ refer</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ severe</td>
<td>□ still symptom</td>
<td>□ refer</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ severe</td>
<td>□ still symptom</td>
<td>□ refer</td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup>REC=Recovered D=Died RF=Refuse Follow up L=Lost A=Admitted
## COVID-19 Suspected Case List (for patients who need confirmatory testing)

<table>
<thead>
<tr>
<th>#</th>
<th>Date of initial diagnostic test (DD/MM/YY)</th>
<th>Case ID or Contact ID</th>
<th>Full Name</th>
<th>Age</th>
<th>Address of Suspected Case (Town/Village and Landmarks)</th>
<th>Date of First Rapid Test (DD/MM/YY)</th>
<th>Scheduled Date of Second Rapid Test (+5 days from first) OR Actual Date of PCR Confirmatory Test (DD/MM/YY)</th>
<th>Results of Second Rapid Test or Confirmatory Test</th>
<th>Suspected Case Next Steps¹ (See codes below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>□ 2ⁿᵈ RDT □ PCR / / / /</td>
<td>□ + □ -</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>□ 2ⁿᵈ RDT □ PCR / / / /</td>
<td>□ + □ -</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>□ 2ⁿᵈ RDT □ PCR / / / /</td>
<td>□ + □ -</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>□ 2ⁿᵈ RDT □ PCR / / / /</td>
<td>□ + □ -</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>□ 2ⁿᵈ RDT □ PCR / / / /</td>
<td>□ + □ -</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>□ 2ⁿᵈ RDT □ PCR / / / /</td>
<td>□ + □ -</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>□ 2ⁿᵈ RDT □ PCR / / / /</td>
<td>□ + □ -</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>□ 2ⁿᵈ RDT □ PCR / / / /</td>
<td>□ + □ -</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>□ 2ⁿᵈ RDT □ PCR / / / /</td>
<td>□ + □ -</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>□ 2ⁿᵈ RDT □ PCR / / / /</td>
<td>□ + □ -</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>□ 2ⁿᵈ RDT □ PCR / / / /</td>
<td>□ + □ -</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>□ 2ⁿᵈ RDT □ PCR / / / /</td>
<td>□ + □ -</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>□ 2ⁿᵈ RDT □ PCR / / / /</td>
<td>□ + □ -</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>/ /</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>□ 2ⁿᵈ RDT □ PCR / / / /</td>
<td>□ + □ -</td>
<td></td>
</tr>
</tbody>
</table>

¹Next Step Codes: RF=Case refuses follow up; N=Follow up not necessary; A=Admitted; L=Lost; M=Move case information to Case Community Monitoring List

Form Version 3
31-Mar-20
2. Intake, Symptoms Screening, Exposure, and Outcomes

Find editable version [here](#).

Note: these forms are combined into one document. If printed front and back the forms are combined into the below:

A. Intake and Symptom Screening for Cases or Contacts

| What | • Demographics and Conditions (front of form):  
|      |   o Demographic information  
|      |   o Maternal, neonatal and child health information  
|      |   o Pre-existing conditions  
|      | • Symptom screening (back of form):  
|      |   o History of illness and fever  
|      |   o Danger signs  
|      |   o Other symptoms  |

| Where | Facility screening or Community. Stays with facility staff if patient is admitted to facility, community health worker if patient is isolating at home or in an isolation facility, or with patient if there is not community follow up available. |

| Who | Facility or Community frontline worker |

| When | Once – at first interaction with individual |

B. Exposure and Final Outcomes for Cases or Contacts

| What | • Exposure (front of form):  
|      |   o General COVID-19 exposure information (travel, occupation, contact with known case)  
|      |   o Contact with COVID-19 case information  
|      | • Final Outcomes (back of form):  
|      |   o Defines final outcomes for Cases (COVID-19 cases). **Note:** that discharge from a facility while the patient is not yet recovered is not a final outcome. Follow up will be required to get final outcome of these patients.  
|      |   o Defines final outcome for Contacts (those who had contact with confirmed cases, but never were confirmed or presumed to be positive). **Note:** final outcome for Contacts includes being converted to a Case if Contact receives a confirmed or presumed COVID-19 diagnosis, a case outcome will be required for these people. |

| Where | Facility or Community. Stays with facility staff if patient is admitted to facility, community health worker if patient is isolating at home or in an isolation facility, or with patient if there is not community follow up available. |

| Who | Facility or Community frontline worker |

| When | Exposure is taken once at first interaction with individual. Final Outcomes is filled when a patient has a final outcome in either the facility or the community. |
## COVID-19 Patient Intake and Symptoms Screening

### 1. Patient Status at Intake

- ☐ Confirmed case
- ☐ Suspected case
- ☐ Contact

1.1 Case ID (if COVID-suspected or -confirmed):

1.2 Contact ID (if close contact of COVID case):

*a person may have a contact and case ID if they started as a contact and then were converted to a case

### 2. Contact Information and Demographics

- 2.1 First name:
- 2.2 Surname:
- 2.3 Sex: ☐ Male ☐ Female
- 2.4 Date of Birth: / / (DD/MM/YYYY)
- 2.5 Age: _______ Years _________ Months
- 2.6 Nearest Health Centre
  - (if <60 months)
- 2.7 Telephone number
- 2.8 National social number/identifier
- 2.9 Other Electronic Number (HIV ID/NCD ID/EMR ID)
- 2.10 Community Health Worker Name
- 2.11 Province/Region if non-national, list country here
- 2.12 District/Commune
- 2.13 Town or Village
- 2.14 Landmark/street name

### 3. Visit Information

- 3.1 Facility Name list community if not in facility
- 3.2 Data collector name
- 3.3 Date of interview / / (DD/MM/YYYY)
- 3.4 Data collector phone number

### 4. Symptoms

4.1 Has the respondent experienced any respiratory symptoms (cough, shortness of breath, sore throat, running nose) in the last 14 days?

- ☐ No
- ☐ Yes

4.2 Fever (≥38 °C) or history of fever

- ☐ No
- ☐ Yes → Start date: / / (DD/MM/YYYY)
  - Maximum temperature: 

4.3 Dry cough

- ☐ No
- ☐ Yes → Start date: / / (DD/MM/YYYY)

### 5. Danger Signs

5.1 Rapid Breathing or Shortness of Breath

- ☐ No
- ☐ Yes → Start date: / / (DD/MM/YYYY)

5.2 Altered consciousness

- ☐ No
- ☐ Yes → Start date: / / (DD/MM/YYYY)

5.3 Inability to eat, drink, or walk

- ☐ No
- ☐ Yes → Start date: / / (DD/MM/YYYY)

If yes to at least one danger sign, patient needs to be seen by clinician immediately

---

Form Version 6
20-Apr-20

Partners In Health
## 6. Other symptoms

<table>
<thead>
<tr>
<th>症状</th>
<th>If Yes to any →</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sore throat</td>
<td></td>
</tr>
<tr>
<td>Chest pain</td>
<td></td>
</tr>
<tr>
<td>Muscle aches (Myalgias)</td>
<td></td>
</tr>
<tr>
<td>Fatigue or general malaise</td>
<td></td>
</tr>
<tr>
<td>Vomiting or Nausea</td>
<td></td>
</tr>
<tr>
<td>Diarrhoea</td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td></td>
</tr>
</tbody>
</table>

- □ Sore throat
- □ Runny nose
- □ Loss of appetite
- □ Muscle aches (Myalgias)
- □ Fatigue or general malaise
- □ Vomiting or Nausea
- □ Diarrhoea
- □ Headache

**Start date for first symptom:**

\[
____/_____/_____
\]

(DD/MM/YYYY)

- □ Chest pain
- □ Loss of appetite
- □ Neurological signs
- □ Seizures
- □ Rash
- □ Conjunctivitis
- □ Other symptoms, specify: ___________________

## 7. Pre-existing Condition(s)

<table>
<thead>
<tr>
<th>状况</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td></td>
</tr>
<tr>
<td>Underweight</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td>Diabetes Type 1</td>
<td></td>
</tr>
<tr>
<td>Diabetes Type 2</td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td></td>
</tr>
<tr>
<td>TB</td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
</tr>
<tr>
<td>Asthma (requiring medication)</td>
<td></td>
</tr>
<tr>
<td>Mental health condition</td>
<td></td>
</tr>
</tbody>
</table>

- □ Obesity
- □ Chronic lung disease (non-asthma)
- □ Underweight
- □ Chronic liver disease
- □ Hypertension
- □ Haematological disorder/Sickle cell disease
- □ Diabetes Type 1
- □ Chronic kidney disease
- □ Diabetes Type 2
- □ Epilepsy
- □ HIV
- □ Chronic neurological impairment/disease
- □ TB
- □ Cancer
- □ Heart disease
- □ Stroke
- □ Asthma (requiring medication)
- □ Other immune deficiency
- □ Mental health condition
- □ Other pre-existing condition:

## 7.2 Smoking

- □ Current
- □ Former
- □ Never

## 7.3 Vaccinated for influenza last 12 months

- □ No
- □ Yes → Date:____/_____/_____

(DD/MM/YYYY)

- □ Unknown

## 7.4 Received pneumococcal vaccine

- □ No
- □ Yes → Date:____/_____/_____

(DD/MM/YYYY)

- □ Unknown

## 8. Maternal and Child Health Information

### 8.1 Pregnant

- □ No
- □ Yes → Trimester: □ First □ Second □ Third □ Unknown

- □ Unknown

- Estimated delivery date:____/_____/_____

(DD/MM/YYYY)

### 8.2 Post-partum Delivery in last 6 months

- □ No
- □ Yes → Delivery date:____/_____/_____

(DD/MM/YYYY)

- □ Unknown

### 8.3 Is patient <1 year old?

- YES → Breastfeeding?

- □ Yes
- □ No
- □ Unknown

### 8.4 Is patient <5 years old?

- YES → Are vaccinations up to date?

- □ Yes
- □ No
- □ Unknown
# COVID-19 Patient Exposure Screening Form

**1. Patient Status**
- [ ] Confirmed case
- [ ] Suspected case
- [ ] Contact

1.1 Case ID (if COVID-suspected or -confirmed):
1.2 Contact ID (if close contact of COVID case):

*a person may have a contact and case ID if they started as a contact and then were converted to a case*

**2. Contact Information and Demographics** (fill if separated from intake form)

2.1 First name:  
2.2 Surname:  
2.3 Telephone number:  
2.4 National social number/ identifier:  
2.5 Province/Region:  
2.6 District/Commune:  
2.7 Town or Village:  
2.8 Landmark/street name:  

**3. General Exposure Information**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Domestically</th>
<th>Internationally</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Have you travelled within the last 14 days?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If YES → Countries, Regions and Cities visited:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start date: __________________________ / __________________________ / (DD/MM/YYYY)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End date: __________________________ / __________________________ / (DD/MM/YYYY)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2 Have you been present in a healthcare facility in the last 14 days?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If YES → Facility: ________________________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If YES to any → location of work or study: ____________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3 Occupation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Health worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Health laboratory worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Student</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other, specify: ____________________________________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**4. In the past 14 days, have you had contact with anyone with suspected or confirmed COVID-19 infection?**

- [ ] Yes → Go to Primary Case Contact Information
- [ ] No → Go to Symptoms Form
- [ ] Unknown → Go to Symptoms Form

**5. Primary Case Contact Information**

Complete if respondent had contact with a known/suspected COVID-19 Case

5.1 Name of primary COVID-19 case:  
5.2 Case ID of primary COVID-19 case:  
5.3 Relationship to primary COVID-19 case:  
5.4 Date of last contact with case:    / / (DD/MM/YYYY)

5.5 Does contact live with primary case?

- [ ] Yes → Number of days during the time the case was ill that were spent within 6 ft of case: __________
- [ ] No
- [ ] Unknown

Number of rooms in the home: __________

Number of residents in the home: __________
# COVID-19 Patient Follow Up Form

## 1. Patient Status
- ☐ Confirmed case
- ☐ Suspected case
- ☐ Contact

### 1.1 Case ID (if COVID-suspected or confirmed):

### 1.2 Contact ID (if close contact of COVID case):

*a person may have a contact and case ID if they started as a contact and then were converted to a case

## 3. Close CONTACT Record

Complete if respondent had contact with a known/suspected COVID-19 Case

### 3.1 What was contact outcome?

- ☐ Completed isolation period without becoming a confirmed or presumed COVID-19 case
- ☐ Lost to follow up
- ☐ Died
- ☐ Refused follow up
- ☐ Became a confirmed or presumed COVID-19 case

→ Go to Close CASE Record

## 4. Close CASE Record

Complete if respondent was a known/suspected COVID-19 Case

### 4.1 What was case outcome?

- ☐ Recovered outside health facility (isolation period ended)
- ☐ Recovered at health facility (discharged)
- ☐ Lost to follow up
- ☐ Died
- ☐ Transferred out (Facility name: __________________________)
- ☐ Refused treatment or follow up
3. Lab Orders and Test Results

Find editable versions [here](#).

### A. Rapid Test Request and Result Form

| What | • Submit orders and specimens to lab for testing  
|      | • Record test results |
| Where | At screening location and in laboratory. Stays with facility staff if patient is admitted to facility, community health worker if patient is isolating at home or in an isolation facility, or with patient if there is not community follow up available. |
| Who | Orders: Completed by Clinical staff  
|      | Results: Completed by Clinical or Laboratory Staff |
| When | When tests are ordered and completed |

### B. Lab Register

| What | • Record basic patient information in one row per patient to easily tally number of each kind of test performed and the results |
| Where | In laboratory. Stays in laboratory. |
| Who | Clinical or Laboratory Staff |
| When | When tests are ordered and completed |
# COVID-19 TEST REQUEST FORM

## 1. Patient Status at Intake

1.1 Case ID (if COVID suspected):

1.2 Contact ID (if close contact of COVID case):

*a person may have a contact and case ID if they started as a contact and then were converted to a case

## 2. Contact Information and Demographics

<table>
<thead>
<tr>
<th>2.1 First name:</th>
<th>2.2 Surname:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>2.3 Sex:</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.4 Date of Birth:</th>
<th>(DD/MM/YYYY)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>2.5 Age:</th>
<th>_______ Years</th>
<th>_______ Months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(if &lt;60 months)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.6 Telephone number</th>
</tr>
</thead>
</table>

Check if patient is a health worker: ☐

## 3. Request Information

<table>
<thead>
<tr>
<th>3.1 Facility Name</th>
<th>[pre-print country here]</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.2 Date of request</th>
<th>(DD/MM/YYYY)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.3 Type of test:</th>
<th>Antibody test (IgM/IgG)</th>
<th>Antigen test</th>
<th>RT PCR test</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.4 Type of specimen:</th>
<th>Nasal swab</th>
<th>Oropharyngeal swab</th>
<th>Venous blood</th>
<th>Finger prick (blood)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.5 Additional info/Comment:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.6 Requested by:</th>
<th>3.7 Signature:</th>
</tr>
</thead>
</table>

---

To be completed in the laboratory

## 4. Specimen/Sample Information

<table>
<thead>
<tr>
<th>4.1 Sample ID:</th>
<th>4.2 Collected by:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4.3 Sample Collection Date and Time:</th>
<th>(DD/MM/YYYY) HH:MM</th>
</tr>
</thead>
</table>

## 5. Test Information

<table>
<thead>
<tr>
<th>5.1 Test Performed by:</th>
<th>5.2 Test Date and Time:</th>
<th>(DD/MM/YYYY) HH:MM</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>5.3 Result Antibody test:</th>
<th>Negative</th>
<th>Positive IgM only</th>
<th>Positive IgG only</th>
<th>Positive IgM and IgG</th>
</tr>
</thead>
</table>

If result is invalid re-do test

<table>
<thead>
<tr>
<th>5.4 Result Antigen test:</th>
<th>Negative</th>
<th>Positive</th>
</tr>
</thead>
</table>

If result is invalid re-do test

<table>
<thead>
<tr>
<th>5.5 Result RT PCR test:</th>
<th>Negative</th>
<th>Positive</th>
<th>Invalid</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.5 Additional info/Comment:</th>
</tr>
</thead>
</table>

Result communicated to: Date of result: (DD/MM/YYYY) Signature:
<table>
<thead>
<tr>
<th>Case ID</th>
<th>Patient Name</th>
<th>Age</th>
<th>Reason</th>
<th>Date of 1st Rapid Test</th>
<th>Antibody Test</th>
<th>Antigen Test</th>
<th>Date of 2nd Rapid Test</th>
<th>Antibody Test</th>
<th>Antigen Test</th>
<th>Date of PCR Test</th>
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</tbody>
</table>
4. Facility-based care for COVID-19 Cases

Find editable versions here. Editable versions of the Facility Admission, Daily Progress, and Discharge forms require a program called Balsamiq (email BostonSIS@pih.org for more information).

### A. Facility Patient Register

| What | Monitors the overall situation in the wards as a way to understand the status of currently and historically admitted cases. Collects information about admission date, basic demographics, COVID-19 and secondary diagnoses, intensive care needed, medications and outcomes |
| Where | Filled in facility ward. Stays in facility. |
| Who | Clinical staff |
| When | Patient information is entered on admission. Staff maintains register throughout treatment receives a facility outcome. (Facility outcome may not be a patient’s final outcome if they are discharged before recovery.) |

### B. Facility Admission Form

| What | Collects information at admission like symptoms, medications, secondary diagnoses |
| Where | Filled in facility ward. Stays in facility unless patient is discharged to recover in home/isolation facility, then forms transfer with patient to a community health worker, or isolation facility staff. If there is no community health worker or isolation facility staff available then forms should stay in facility. |
| Who | Clinical staff |
| When | Filled upon admission to health facility |

### C. Facility Daily Progress Form

| What | Daily assessment of vitals and lab results and admission to intensive care |
| Where | Filled in facility ward. Stays in facility unless patient is discharged to recover in home/isolation facility, then forms transfer with patient to a community health worker, or isolation facility staff. If there is no community health worker or isolation facility staff available then forms should stay in facility. |
| Who | Clinical Staff |
| When | Filled daily for any number of days admitted to the facility |

### D. Facility Discharge Form

| What | Discharge information for patients upon leaving the facility, includes secondary diagnoses and medications given to patient upon discharge |
| Where | Filled in facility ward. Stays in facility unless patient is discharged to recover in home/isolation facility, then forms transfer with patient to a community health worker, or isolation facility staff. If there is no community health worker or isolation facility staff available then forms should stay in facility. |
| Who | Clinical Staff |
| When | Filled at time of discharge from facility |
COVID-19 Patient Treatment Register

<table>
<thead>
<tr>
<th>Date of Admission D/M/Y</th>
<th>Case ID</th>
<th>Patient Name</th>
<th>Age</th>
<th>Sex</th>
<th>Secondary Diagnosis</th>
<th>COVID-19 Suspected or Confirmed</th>
<th>Admit to ICU</th>
<th>ICU Start Date</th>
<th>ICU End Date</th>
<th>Intensive Care</th>
<th>Medication</th>
<th>Discharge Date D/M/Y</th>
<th>Outcome Date D/M/Y</th>
<th>Outcome (see codes below)</th>
<th>Transfer Out Facility</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

**OUTCOME CODES:**

**REC**=Recovered at facility and discharged, **ISO**=Discharged to Isolation/unwell,  
**TO**=Transfer Out, **REF**=Refused Care, **D**=Died

Version 3
12-Jun-20

Page #: ___________
# Admission Note

**Date:** ____________

**Time:** ____________

## Patient Demographics

- Employed as Healthcare Worker: [ ] Yes [ ] No
- Type: ____________
- Patient is pregnant? [ ] Yes [ ] No
- Gestational Age: ____________ weeks
- Or Expected Due Date: ____________
- Post-partum patient? [ ] Yes [ ] No
- Outcome: [ ] live birth [ ] still birth
- Delivery Date: ____________
- Patient is infant? [ ] Yes [ ] No
- Gestational Outcome: [ ] Term birth (<37 wk GA) [ ] Premature birth (<37 wk GA)
- Breastfed: [ ] Yes [ ] No
- If child, vaccinations up to date? [ ] Yes [ ] No

## Home Medications

<table>
<thead>
<tr>
<th>Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>None [ ] [ ] Unknown</td>
</tr>
<tr>
<td>Type 1 Diabetes [ ] Chronic kidney disease [ ]</td>
</tr>
<tr>
<td>Type 2 Diabetes [ ] Asthma [ ]</td>
</tr>
<tr>
<td>Hypertension [ ] Chronic pulmonary disease (asthma) [ ]</td>
</tr>
<tr>
<td>Epilepsy [ ] Tuberculosis [ ]</td>
</tr>
<tr>
<td>Sickle Cell disease [ ] Cardiomyopathy [ ]</td>
</tr>
<tr>
<td>Rheumatic Heart Disease [ ] Stroke [ ]</td>
</tr>
<tr>
<td>HIV [ ] Mainutrition [ ]</td>
</tr>
</tbody>
</table>

## Comorbidities

- Mental Health Condition:
- Smoking: [ ] Current [ ] Past [ ] Never

## Onset/Admission

- Transfer from other facility? [ ] Yes [ ] No
- Transfer Facility: ________
- Admission Date: ____________
- Known contact with COVID-19 patient in 14 days prior to symptoms [ ] Yes [ ] No
- Admission Condition Status: [ ] Mild [ ] Moderate [ ] Critical

## First Line Medications

- specify:

## Second Line Medications

- [ ] Lopinavir/ritonavir (dosing/dosing 500 mg 12 h 1 60 days
- [ ] Remdesivir
- [ ] Other:

## Antibiotics

- [ ] Ceftriaxone _______ mg _______ hour
- [ ] Amodulin _______ mg _______ hour
- [ ] Doxycycline 160 mg Bb

## Signs and Symptom

- Fever [ ] Chest pain [ ]
- Cough [ ] Muscles aches (Myalgias) [ ]
- With sputum production [ ] Fatigue/malaise [ ]
- Shortness of breath (Dyspnea) [ ] Nausea/vomiting [ ]
- Sore throat [ ] Diarrhea [ ]
- Runny nose [ ] Loss of taste/smell [ ]
- Headache [ ] Confusion [ ]
- Other, specify:

## Vitals

<table>
<thead>
<tr>
<th>Temp</th>
<th>°C</th>
<th>°F</th>
<th>Cap refill time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>[ ] &lt; 3 sec [ ] ___ sec</td>
</tr>
</tbody>
</table>

- Pulse: ___ bpm
- RR: ___ bpm
- BP: ___ mmHg
- SPO2 % on ___ L/min [ ] room air

## Physical Exam

### System

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>HEENT</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Neck</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Cardiovascular</td>
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<td>[ ] No</td>
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<td>Abdominal</td>
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<td>Rectal</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
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<tr>
<td>Musculoskeletal</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
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<td>Lymph nodes</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
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<tr>
<td>Skin and mucosa</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Neurological</td>
<td>[ ] Alert</td>
<td>[ ] Verbal</td>
</tr>
</tbody>
</table>

## Supportive Care

- [ ] Oxygen _______ L/min
- [ ] Analgesic _______ milligram

- [ ] Mechanical Ventilation
- [ ] Mask
- [ ] Mask with non-rebreather
- [ ] Nasal Cannula
- [ ] CPAP
- [ ] BIPAP
- [ ] FIO2
- [ ] V Fluids _______ milliliter

## Other Medications

- [ ] Central [ ] Peripheral
- [ ] Central [ ] Peripheral
- [ ] Central [ ] Peripheral

## Other

- [ ] Alert [ ] Verbal [ ] Pain [ ] Unresponsive
## Admission Note

### COVID-19 Testing

<table>
<thead>
<tr>
<th>Specimen Date</th>
<th>Specimen Type</th>
<th>Test Type</th>
<th>Test Result</th>
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</thead>
<tbody>
<tr>
<td><em><strong>/</strong></em>/___</td>
<td>Nosal swab</td>
<td>Antibody test (IgM/IgG)</td>
<td>□ Negative □ Positive IgM □ Positive IgG □ invalid □ positive IgM and IgG</td>
</tr>
<tr>
<td></td>
<td>Oral pharyngeal swab</td>
<td>Antigen test</td>
<td>□ Negative □ Positive □ invalid</td>
</tr>
<tr>
<td></td>
<td>Venous blood</td>
<td>RT PCR test</td>
<td>□ Negative □ Positive □ invalid</td>
</tr>
<tr>
<td></td>
<td>Finger prick (blood)</td>
<td>Geneexpert</td>
<td>□ Negative □ Positive □ invalid</td>
</tr>
<tr>
<td><em><strong>/</strong></em>/___</td>
<td>Nosal swab</td>
<td>Antibody test (IgM/IgG)</td>
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<td></td>
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<td>Geneexpert</td>
<td>□ Negative □ Positive □ invalid</td>
</tr>
</tbody>
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### Other testing

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<th>Result</th>
<th>Test</th>
<th>Result</th>
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<tr>
<td>Haemoglobin</td>
<td>%</td>
<td>Lymphocyte count</td>
<td>%</td>
</tr>
<tr>
<td>Haematocrit</td>
<td>%</td>
<td>Neutrophil count</td>
<td>%</td>
</tr>
<tr>
<td>WBC count</td>
<td>x10^9/L or x10^6/μL</td>
<td>Lactate</td>
<td>mmol/L</td>
</tr>
<tr>
<td>Platelets</td>
<td>x10^12/L or x10^9/μL</td>
<td>CRP</td>
<td>mg/L</td>
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### ABC Test:

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<tr>
<th>pH</th>
<th>PO2</th>
<th>HCO3</th>
<th>BE</th>
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<tbody>
<tr>
<td></td>
<td>mmHg</td>
<td>mEq/L</td>
<td>mmol/L</td>
</tr>
</tbody>
</table>

### Disposition:

- □ Admit to ward
- □ Admit to COVID-19 Isolation
- □ Discharge
- □ Left against medical advice
- □ Death
- □ Quarantine at home
- □ Quarantine Facility
- □ Transfer to: ___

### Diagnosis

COVID-19: □ Confirmed □ Suspected □ No

Secondary/Other Diagnoses: ___

### Provider Clinical Plan:

___

### Nursing Admission Note

___

Signature: __________________

Name: ___________________ Signature: ______
Daily Progress Note

Date: ____________ Time: ____________

Current Condition State: ☐ Mild ☐ Moderate ☐ Severe ☐ Critical

Transfer from: ☐ COVID-19 Isolation ☐ Hospital ☐ Other

Vitals

<table>
<thead>
<tr>
<th>Symptom</th>
<th>New</th>
<th>Improved</th>
<th>Unchanged</th>
<th>Worsened</th>
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<tbody>
<tr>
<td>Fever</td>
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<tr>
<td>Cough</td>
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<td>With sputum production</td>
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<tr>
<td>Sore throat</td>
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<td>Diarrhea</td>
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<tr>
<td>Confusion</td>
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<tr>
<td>Loss of taste/smell</td>
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<tr>
<td>Headache</td>
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</tbody>
</table>

First Line Medications

Specify:

Second Line Medications

☐ Lopinavir/ritonavir 400mg/100mg PO q12h x 14 days
☐ Remdesivir

Antibiotics

☐ Ceftriaxone _____ gm a _____ hours  ☐ Amoxicillin _____ gm a _____ hours
☐ Doxycycline 100 mg BD  ☐ Other: __________________________

Physical Exam

<table>
<thead>
<tr>
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<td>Skin and mucosa</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Neurological</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

Other, specify:

Primary Diagnoses:

COVID-19: ☐ Confirmed ☐ Suspected ☐ No
Other: ____________________________

Secondary Diagnoses:

Pneumonia ☐  Congestive heart failure ☐
Acute Respiratory Distress Syndrome ☐  Myocarditis ☐
Pleur effusion ☐  Acute renal injury/ Acute renal failure ☐
Anemia ☐  Liver dysfunction ☐
Meningitis/ Encephalitis ☐  Hyperglycemia ☐
Seizure ☐  Hypoglycemia ☐
Dehydration ☐  Cardiac arrest ☐
Metabolic disorders ☐  Meningoencephalitis ☐
Other: ____________________________

Supportive Care

☐ Oxygen _______ L/min  ☐ Analgesic: __________________________
☐ Mechanical Ventilation ☐ Mask  ☐ Mask with non-rebreather
☐ Nasal Cannula ☐ CPAP ☐ BIPAP ☐ FIO2
☐ IV Fluids _______ ml/hour specify: __________________________
☐ Central ☐ Peripheral
☐ IV Fluids _______ ml/hour specify: __________________________
☐ Central ☐ Peripheral
☐ IV Fluids _______ ml/hour specify: __________________________
☐ Central ☐ Peripheral
## Daily Progress Note

### Testing

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
<th>Test</th>
<th>Result</th>
<th>Test</th>
<th>Result</th>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>SARS-CoV-2 Antibody</td>
<td></td>
<td>SARS-CoV-2 Antigen</td>
<td></td>
<td>SARS-CoV-2 RT-PCR</td>
<td></td>
<td>GeneXpert</td>
<td></td>
</tr>
<tr>
<td>Negative Ab</td>
<td></td>
<td>Negative</td>
<td></td>
<td>Negative</td>
<td></td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td>Positive IgM only</td>
<td></td>
<td>Positive</td>
<td></td>
<td>Positive</td>
<td></td>
<td>Invalid</td>
<td></td>
</tr>
<tr>
<td>Positive IgG+IgM</td>
<td></td>
<td>Invalid</td>
<td></td>
<td>Invalid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive IgG only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemoglobin</td>
<td>g/l or g/dL</td>
<td>Lymphocyte count</td>
<td>cells/µL</td>
<td>Sodium</td>
<td>mmol/L</td>
<td>Total Bilirubin</td>
<td>µmol/L</td>
</tr>
<tr>
<td>Haematocrit</td>
<td>%</td>
<td>Neutrophil count</td>
<td>cells/µL</td>
<td>Potassium</td>
<td>mmol/L</td>
<td>ALT/SGPT</td>
<td>U/L</td>
</tr>
<tr>
<td>WBC count</td>
<td>x10³/µL or x10³/µL</td>
<td>Lactate</td>
<td>mmol/L or mg/dL</td>
<td>BUN</td>
<td>mmol/L or mg/dL</td>
<td>AST/SGOT</td>
<td>U/L</td>
</tr>
<tr>
<td>Platelets</td>
<td>x10³/µL or x10³/µL</td>
<td>CRP</td>
<td>mg/L</td>
<td>Creatinine</td>
<td>µmol/L or mg/dL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABG Test:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pH</td>
<td></td>
<td>PO2</td>
<td>mmHg</td>
<td>HCO₃⁻</td>
<td>mmol/L</td>
<td>BE</td>
<td>mmol/L</td>
</tr>
<tr>
<td>PCO₂</td>
<td>mmHg</td>
<td>TCO₂</td>
<td>mmol/L</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Abdominal Ultrasound
- Cardiac Ultrasound

Other findings:

Other diagnostic tests:

### Disposition

- Admit to ward
- Admit to COVID-19 Isolation
- Quarantine at home
- Left against medical advice
- Discharge
- Death
- Quarantine Facility
- Transfer to:

### Provider Clinical Plan

- Provider's clinical plan

### Nursing Progress Note

- Nursing progress note

Signature: __________________________

Name: __________________________ Signature: __________________________
# Discharge Note

**Date:** ______________  **Time:** ______________

**Patient Name:** ______________  **Patient Id:** ______________

**Age:** ______________  **EMR Id:** ______________

**Sex:** ______________  **Hospital day #:** ______________

## Primary Diagnoses:

- [ ] COVID-19: Confirmed
- [ ] Suspected
- [ ] No

**Other:**

## Secondary Diagnoses:

- [ ] Pneumonia
- [ ] Congestive heart failure
- [ ] Acute Respiratory Distress Syndrome
- [ ] Myocarditis
- [ ] Pleural effusion
- [ ] Acute renal injury
- [ ] Acute renal failure
- [ ] Chronic
- [ ] Anemia
- [ ] Liver dysfunction
- [ ] Meningitis/Encephalitis
- [ ] Hyperglycemia
- [ ] Seizure
- [ ] Hypoglycemia
- [ ] Dehydration
- [ ] Cardiac arrest
- [ ] Metabolic disorders
- [ ] Meningoencephalitis

**Other:**

## Therapy given during hospital stay

- [ ] Oxygen Therapy?
  - [ ] Yes
  - [ ] No
- [ ] Non-invasive ventilation? (e.g. BIPAP, CPAP)
  - [ ] Yes
  - [ ] No
- [ ] Inotropes/vasopressors?
  - [ ] Yes
  - [ ] No
- [ ] Antibiotics?
  - [ ] Yes
  - [ ] No

## Other intervention of Procedure:

## Discharge Information

**Discharge Date:** _____/_____/

**Disposition:**
- [ ] Discharged to home
- [ ] Transfer to other facility
- [ ] Death
- [ ] Other (specify): ___________________________

**Discharge condition:**
- [ ] Good/recovered
- [ ] Fair
- [ ] Poor

**Follow up plan:**

**Other comments:**

---

**Name** ____________________________  **Signature** ____________________________
Introduction: Below describes PIH’s approach to Cleaning and Disinfecting throughout the COVID-19 pandemic. Please do not hesitate to reach out with questions to the COVID-19@pih.org.

1. Cleaning and Disinfecting Guidelines
2. Cleaning Clinical Spaces
3. Cleaning Non Clinical Spaces
4. COVID19 Transport guidelines
5. Acceptable Disinfectants
6. Liquid Chlorine Preparation (English and French)

Cleaning and Disinfecting Guidelines

1. Prepare
   • Don disposable gloves
   • Close off areas to be cleaned
   • Wait as long as practical before beginning cleaning and disinfection
   • Open outside doors and windows
2. Clean (Clean surfaces using a detergent or soap and water before disinfection)
   • Remove visible pollutants (blood, secretions, excreta)
   • Damp mopping is better than dry mopping
   • Wash Surfaces that have come into direct human contact or are frequently touched
   • Sterilize all cleaning materials used
3. Disinfect
   • Prepare Solution using Acceptable Disinfectant guidelines
   • Wipe the area with the disinfectant solution using a cloth
   • Start with cleaner regions first, and contaminated regions after
   • Dispose or sterilize cloth immediately after use
   • Doff disposable gloves immediately after disposing cloth
   • Perform hand hygiene using soap and water. (If water is unavailable, clean hands with alcohol-based hand rub)
# Cleaning Clinical Areas

**Including Isolation units: COVID-19 Cleaning and Disinfection Instructions**

<table>
<thead>
<tr>
<th>Type of Surface</th>
<th>Examples</th>
<th>Soap and Water</th>
<th>Disinfect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimally Touched</strong>&lt;br&gt;Surfaces</td>
<td>Floors&lt;br&gt;Ceilings&lt;br&gt;Walls&lt;br&gt;Windows</td>
<td>When Dirty. At least 3 times/ week.</td>
<td>After Human Contact /When Dirty. At least weekly.</td>
</tr>
<tr>
<td><strong>Frequently Touched</strong>&lt;br&gt;Surfaces</td>
<td>Door Handles, Table&lt;br&gt;Top&lt;br&gt;Desks, Light&lt;br&gt;Switches, Computers,&lt;br&gt;Sinks/Basins</td>
<td>Daily</td>
<td>Daily</td>
</tr>
</tbody>
</table>

**Disposal of Excreta**

Conduct hand hygiene, treat feces as biohazard, disposed in separate toilet/latrine for suspected or confirmed cases of COVID-19, clean bedpan with neutral detergent & water, disinfected with a 1% chlorine or 0.5% sodium hypo-chlorite solution.

**Laundry**

- Place soiled linen placed in leak-proof bags/containers, removing solid excrement to be disposed of in a toilet/latrine. Machine washing recommended (warm water at 60–90° C with laundry detergent).
- If machine washing not possible, soak linens in hot water and soap in a large drum using a stick to stir > soak linens in 1% chlorine for approximately 30 minutes > rinse laundry with clean water > dry fully in sunlight.
# Cleaning Non-Clinical Spaces

<table>
<thead>
<tr>
<th>Type of Surface</th>
<th>Examples</th>
<th>Soap and Water</th>
<th>Disinfect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimally Touched Surfaces</strong></td>
<td>Floors, Ceilings, Walls, Blinds</td>
<td>3 times daily + any known COVID-exposure</td>
<td>3 times daily + any known COVID-exposure</td>
</tr>
<tr>
<td><strong>Frequently Touched Surfaces</strong></td>
<td>Door Handles, Table Tops / Desks, Light Switches, Computers, Sinks/Basins</td>
<td>3 times daily + between each patient</td>
<td>3 times daily + between each patient</td>
</tr>
</tbody>
</table>
COVID-19 Transport Guidelines
Updated: 24 March 2020

1. General Hygiene Guidelines for Drivers and Transport Staff
   a. If possible, wear new disposable gloves for every journey
   b. If not wearing gloves: Before, during, and after each trip, wash your hands with soap and water for at least 20 seconds. Use an alcohol-based hand sanitizer that contains at least 60 percent alcohol if soap and water are not available.
   c. Avoid touching your face, eyes, nose, or mouth with unwashed hands.
   d. Avoid close contact with passengers
   e. If possible, ask passengers to sit in the back to create physical distance.
   f. Have hand sanitizer available for both driver and passengers
   g. Please reference JOB AID Rwanda Evac for evacuating positive patients to treatment centers

2. Vehicle Disinfection
   a. Routine Cleaning/Disinfection – Before and After each trip and at the end of each shift/day
      1. Use a 70% alcohol-based solution (or soap and water if not available) to wipe down all high-touch surfaces: steering wheel, shifter, door handles, windows, any other area that has been touched by passengers or driver
      2. Deep cleaning – After each trip carrying symptomatic patients, follow routine cleaning plus: Full cleaning of all passenger areas, including: floor, passenger seat, back of front seat, door, window, etc.
   b. If proper cleaning/disinfection cannot be performed, leave vehicle unused for minimum 48 hours

Recommended Minimum Cleaning and Disinfecting Frequencies

<table>
<thead>
<tr>
<th>Type of Surface</th>
<th>Examples</th>
<th>Soap and Water</th>
<th>Disinfect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimally Touched</td>
<td>Exterior, Headliner, Trunk</td>
<td>When Dirty</td>
<td>Only after Human Contact</td>
</tr>
<tr>
<td>Surfaces</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequently Touched</td>
<td>Door Handles, Switches,</td>
<td>Routinely</td>
<td>High Touch Areas</td>
</tr>
<tr>
<td>Surfaces</td>
<td>Dashboard, Carpet, Seats</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Steering</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wheel, Shifter, Keys, Interior</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Windows</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Choosing the Right Disinfectant (please see below for acceptable disinfectants)

- Use an Alcohol-based cleaner for cars.
- Avoid: Chlorine Bleach as it can damage plastic, fabric and metal
- DO NOT MIX SOLUTIONS
### Trip Guidelines

<table>
<thead>
<tr>
<th><strong>Low-Risk Trips</strong></th>
<th><strong>Medium-Risk Trips</strong></th>
<th><strong>High-Risk Trips</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>As many carriers of COVID-19 are asymptomatic, the only no-risk journey is by yourself.</td>
<td>Non-medical trips, including carrying asymptomatic close contacts, Medical trips carrying patients with other conditions (trauma, obstetric), No high-risk passengers (pre-existing health conditions, elderly, etc.)</td>
<td>Symptomatic patients, Patients in high-risk categories (pre-existing health conditions, elderly, etc.)</td>
</tr>
<tr>
<td>a. PPE (Mask and Gloves) Recommendations: follow general hygiene guidelines</td>
<td>b. PPE (Mask and Gloves) Recommendations</td>
<td>Symptomatic and high-risk passengers should only travel for purposes of medical treatment</td>
</tr>
<tr>
<td>b. Follow routine cleaning instructions above</td>
<td>a. Masks and gloves highly recommended for passengers and driver</td>
<td>d. PPE (Mask and Gloves) Recommendations: Masks and gloves must be worn by all occupants in the vehicle</td>
</tr>
<tr>
<td>c. Maximum capacity: 1 (driver only)</td>
<td>b. Follow routine cleaning instructions above.</td>
<td>e. For moving patients, wear appropriate full PPE, including eye protection, gown and gloves</td>
</tr>
<tr>
<td></td>
<td>c. Maximum Capacity: 4</td>
<td>f. After helping a medical passenger out of the car, you should remove all protective equipment and wash your hands or use hand sanitizer before getting back into your vehicle.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>g. Follow routine and deep cleaning instructions above</td>
</tr>
<tr>
<td></td>
<td></td>
<td>h. Maximum Capacity: 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Keep windows open during trip</td>
</tr>
</tbody>
</table>
# Acceptable Disinfectants

<table>
<thead>
<tr>
<th>Disinfecting Solution</th>
<th>Concentration</th>
<th>Directions</th>
<th>Use on</th>
<th>Do NOT use on</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diluted chlorine bleach (5.25% sodiumhypochlorite)</td>
<td>0.5% (1:50)</td>
<td>Apply, leave for 10 min, rinse</td>
<td>Floors, desks, non-porous surfaces</td>
<td>Computers, phones, screens, fabric, can discolor plastic, metal</td>
</tr>
<tr>
<td>Chlorine</td>
<td>.5%</td>
<td>Apply, leave for 10 min, rinse</td>
<td>Floors, desks, non-porous surfaces</td>
<td>Computers, phones, screens, fabric, can discolor plastic, metal</td>
</tr>
<tr>
<td>Hydrogen Peroxide</td>
<td>0.5%</td>
<td>Apply</td>
<td>Floors, desks, non-porous surfaces, metal</td>
<td>Fabric</td>
</tr>
<tr>
<td>Ethanol / Ethyl Alcohol</td>
<td>62% minimum</td>
<td>Apply</td>
<td>Computers, Phones, Non-porous surfaces</td>
<td>Can discolor plastic</td>
</tr>
<tr>
<td>Isopropyl Alcohol</td>
<td>70% minimum</td>
<td>Apply</td>
<td>Computers, Phones, Non-porous surfaces</td>
<td>Can discolor plastic</td>
</tr>
<tr>
<td>Propanol</td>
<td>70% minimum</td>
<td>Apply</td>
<td>Computers, Phones, Non-porous surfaces</td>
<td>Can discolor plastic</td>
</tr>
</tbody>
</table>

**Do NOT use: Ammonia, vinegar  Do NOT: mix multiple disinfectants**

Preparation and use of disinfectant solution
- Gloves should be worn when handling and preparing bleach solutions.
- Protective eye wear should be worn in case of splashing.
- Cleaning solutions) should be made up daily.
- Leave the disinfectant solution on the surface for a sufficient time is required to kill the virus – 1 minute for alcohol based cleaners.
Liquid Chlorine Preparation

*English Version – Updated 23 March 2020*

<table>
<thead>
<tr>
<th>% Solution</th>
<th>0,05 %</th>
<th>0,5 %</th>
<th>2 %</th>
<th>Use for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hands, skin, laundry, clothes</td>
<td>Floors, walls, equipment</td>
<td>Disinfection of stool, vomit, blood. Disinfection of corpses.</td>
<td></td>
</tr>
<tr>
<td>Bleach, 5% sodium hypochlorite (5 % active chlorine)</td>
<td>10 milliliters in 10 liters of water</td>
<td>1 liter in 10 liters of water</td>
<td>4 liters in 6 liters of water</td>
<td></td>
</tr>
<tr>
<td>Chlorine laundry powder (30% active chlorine)</td>
<td>16 grams (1 tablespoon) in 10 liters of water</td>
<td>16 grams (1 tablespoon) in 1 liter of water</td>
<td>64 grams (4 tablespoons) in 1 liter of water</td>
<td></td>
</tr>
<tr>
<td>Chlore en granules (HTH) (70 % de chlore actif)</td>
<td>8 grams (1/2 tablespoon) in 10 liters of water</td>
<td>8 grams (1/2 tablespoon) in 1 liter of water</td>
<td>32 grams (2 tablespoons) in 1 liter of water</td>
<td></td>
</tr>
</tbody>
</table>

ALWAYS label solutions using an permanent marker

Note: WaterGuard is 1.25% Sodium Hypochlorite --> if this is used, then will need to use different ratios
## Liquid Chlorine Preparation

*Version française – Mis à jour 23 March 2020*

<table>
<thead>
<tr>
<th>Préparation de solution chlorée</th>
<th>0,05 %</th>
<th>0,5 %</th>
<th>2 %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Solution de:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Utilisé pour:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mains, peau, linge, vêtements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sols, surfaces, équipements</td>
<td></td>
<td></td>
<td>Gestion de selles et vomissement (désinfectées dans des seaux), Désinfection de cadavres</td>
</tr>
</tbody>
</table>

### Produit de base

<table>
<thead>
<tr>
<th>JIF, Klowoks liquide (5 % de chlore actif)</th>
<th>10 millilitres dans 10 litres d’eau*</th>
<th>1 litre dans 10 litres d’eau*</th>
<th>4 litres dans 6 litres d’eau</th>
</tr>
</thead>
<tbody>
<tr>
<td>Klowoks en poudre pour blanchissment de vêtements (30 % de chlore actif)</td>
<td>1 cuillère à soupe (16 grammes) dans 10 litres d’eau*</td>
<td>1 cuillère à soupe (16 grammes) dans 1 litre d’eau</td>
<td>4 cuillères à soupe (64 grammes) dans 1 litre d’eau</td>
</tr>
<tr>
<td>Chlore en granules (HTH) (70 % de chlore actif)</td>
<td>1/2 cuillère à soupe (7 grammes) dans 10 litres d’eau*</td>
<td>1/2 cuillère à soupe (7 grammes) dans 1 litre d’eau</td>
<td>2 cuillères à soupe (28 grammes) dans 1 litre d’eau</td>
</tr>
</tbody>
</table>
ALWAYS label solutions using an permanent marker

Note: WaterGuard is 1.25% Sodium Hypochlorite --> if this is used, then will need to use different ratios
Introduction: Below describes PIH’s approach to PPE usage throughout the COVID-19 pandemic. Please do not hesitate to reach out with questions to the COVID-19@pih.org

1. PPE conservation
2. PPE Conservation posters (English, French, Spanish)
3. Extended use and reuse of masks and eye protection
4. Extended Use PPE – donning and doffing
5. Nonstandard PPE Memo

PIH Guide to PPE Conservation

Our priority is the safety of our patients and healthcare workers. It is CRITICAL that as triage and isolation systems are rapidly planned and implemented, early efforts are made to conserve PPE as global stock is limited. Conserving PPE now will ensure enough supplies to keep providers safe throughout the pandemic

Strategically Reduce Individual PPE Use

• Extend Use & Re-Use: Extended use is preferred over reuse. Extended use of respiratory protection is defined as the wearing of a disposable mask without removal or re-donning of the mask. Due to the rapidly evolving epidemic and to ensure protection for the frontline health workers many organizations, including the CDC is recommending re-use when necessary. See below for safe re-use procedures.
• Concentrate Care Delivery: Develop Strategies to complete multiple task utilizing the same set of PPE. For example: taking vital signs and giving medication at the same time.
• Appropriate use of PPE: WHO recommends the use of a surgical mask for the routine care of suspected COVID patients, and the use of N95 in COIVD patients during aerosolizing procedures like intubation or nebulization. When able N95 masks should be replaced after any aerosolizing procedure however, re-use of N95 masks may be necessary. N95 masks should be used according to PIH protocols for TB treatment

Reuse PPE:

Face Shields: Reusable face shields can be soaked in sodium hypochlorite 0.5% for 1 hour and left in a clean, open space to dry for at least 1 hour

Gowns: In some wards, gowns may need to be worn continuously as a provider moves between patients. In these cases, the provider should double glove and change outer gloves between patients. If gowns are in short supply, re-usable gowns can be considered. (see PIH guidelines on alternative PPE). If reusable gowns are used they should be machine washed with 60-90° C water and laundry detergent

Surgical and Procedural Masks: Given current supply global levels, most hospitals will need extended use of masks between patients (meaning that the mask is not removed between
patients but stays on a provider’s face continuously). At many hospitals, masks will need to be re-used (meaning removed from the face and then put back on in between patients). PIH has a job aid to assist with safe re-use of mask. Key tenants of this include:

- Surgical and procedural masks must be worn by a single wearer.
- The removed mask should be placed in a designated receptacle for reuse.
- Perform hand hygiene immediately before and after putting on or otherwise touching a reused mask.
- Masks must be replaced when dirty or contaminated

Our priority is the safety of our patients and healthcare workers. It is CRITICAL that as triage and isolation systems are rapidly planned and implemented, early efforts are made to conserve PPE as stock is limited globally. Conserving PPE now will ensure enough supplies to keep providers safe throughout the epidemic – how to safely conserve and re-use PPE?

**Minimize Number of People using PPE**

- **On Patient Rounds:** Consider only having direct caregivers interact with the patient rather than members of the team responsible for the care of other patients
- **On Shift:** Designate a subset of caregivers to operate in the isolation area, rather than more providers in both areas. All caregivers can adhere to the above strategies to reduce PPE usage
- **In the Operating Room:** Limit surgeries to only essential surgeries and limit the number of observes and non-essential personnel, reducing the number of PPE sets used.
- **In General:** No visitors for patients suspected or confirmed to have COVID-19 (with the exception of parents for children). Visitors cannot enter COVID-19 isolation ward.

**Role for hospital administrators:**

Hospital administration should actively enforce PPE conservation measures. Some strategies used include:

- Removing or limiting PPE on wards less likely to require them
- Centralized PPE distribution instead of PPE stored on wards
- PPE monitors who can correct individuals when PPE is overused (for example, if an N95 mask is used in a situation where a surgical mask would have been sufficient)
PIH GUIDELINES FOR PERSONAL PROTECTIVE EQUIPMENT (PPE) CONSERVATION

Our priority is the safety of our patients and healthcare workers. It is CRITICAL that as triage and isolation systems are rapidly planned and implemented, early efforts are made to conserve PPE as global stock is limited. Conserving PPE now will ensure enough supplies to keep providers safe throughout the pandemic.

STRATEGICALLY REDUCE INDIVIDUAL PPE USE

| Extend Use & Re-Use | Extended use is preferred over reuse. Extended use of respiratory protection is defined as the wearing of a disposable mask without removal or re-donning of the mask. Due to the rapidly evolving epidemic and to ensure protection for the frontline health workers many organizations, including the CDC is recommending re-use when necessary and safe. See below for safe re-use procedures. |
| Concentrate Care Delivery | Develop Strategies to complete multiple task utilizing the same set of PPE. For example: taking vital signs and giving medication at the same time. |
| Appropriate use of PPE | WHO recommends the use of a surgical mask for the routine care of suspected COVID patients, and the use of N95 in COVID patients during aerosolizing procedures like intubation or nebulization. When able N95 masks should be replaced after any aerosolizing procedure however, re-use of N95 masks may be necessary. N95 masks should be used according to PIH protocols for TB treatment. |

REUSE PPE

**Face Shields.** Reusable face shields can be soaked in sodium hypochlorite 0.5% for 1 hour and left in a clean, open space to dry for at least 1 hour.

**Gowns.** In some wards, gowns may need to be worn continuously as a provider moves between patients. In these cases, the provider should double glove and change outer gloves between patients. If gowns are in short supply, re-usable gowns can be considered. (see PIH guidelines on alternative PPE). If reusable gowns are used they should be machine washed with 60-90° C water and laundry detergent

**Surgical and procedural masks.** Given current supply global levels, most hospitals will need extended use of masks between patients (meaning that the mask is not removed between patients but stays on a provider’s face continuously). At many hospitals, masks will need to be re-used (meaning removed from the face and then put back on in between patients). PIH has a job aid to assist with safe re-use of mask. Key tenants of this include:

- Surgical and procedural masks must be worn by a single wearer.
- The removed mask should be placed in a designated receptacle for reuse.
- Perform hand hygiene immediately after putting on or otherwise touching a reused mask.
- Masks must be replaced when dirty or contaminated.
**PIH GUIDELINES FOR PERSONAL PROTECTIVE EQUIPMENT (PPE) CONSERVATION**

Our priority is the safety of our patients and healthcare workers. It is **CRITICAL** that as triage and isolation systems are rapidly planned and implemented, early efforts are made to **conserve PPE** as global stock is limited. Conserving PPE now will ensure enough supplies to keep providers safe throughout the pandemic.

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**MINIMIZE NUMBER OF PEOPLE USING PPE**

- **On Patient Rounds**
  Consider only having direct caregivers interact with the patient rather than members of the team responsible for the care of other patients.

- **On Shift**
  Designate a subset of caregivers to operate in the isolation area, rather than more providers in both areas. All caregivers can adhere to the above strategies to reduce PPE usage.

- **In the Operating Room**
  Limit surgeries to only essential surgeries and limit the number of observes and non-essential personnel, reducing the number of PPE sets used.

- **In General**
  No visitors for patients suspected or confirmed to have COVID-19 (with the exception of parents for children). Visitors cannot enter COVID-19 isolation ward.

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**ROLE FOR HOSPITAL ADMINISTRATORS**

Hospital administration should actively enforce PPE conservation measures.

Some strategies used include:

- Removing or limiting PPE on wards less likely to require them
- Centralized PPE distribution instead of PPE stored on wards
- PPE monitors who can correct individuals when PPE is overused (for example, if an N95 mask is used in a situation where a surgical mask would have been sufficient)
Une utilisation prolongée est préférable à une réutilisation. L’utilisation prolongée d’une protection respiratoire est définie comme le port d’un masque jetable sans qu’il ne soit retiré ni ré-enfilé. En raison de l’évolution rapide de l’épidémie et pour assurer la protection des agents de santé de première ligne, de nombreuses organisations, y compris le CDC, recommandent la réutilisation, si nécessaire. Voir les procédures sûres de réutilisation ci-dessous.

**Prolongez l’utilisation & la réutilisation**

Une utilisation prolongée est préférable à une réutilisation. L’utilisation prolongée d’une protection respiratoire est définie comme le port d’un masque jetable sans qu’il ne soit retiré ni ré-enfilé. En raison de l’évolution rapide de l’épidémie et pour assurer la protection des agents de santé de première ligne, de nombreuses organisations, y compris le CDC, recommandent la réutilisation, si nécessaire. Voir les procédures sûres de réutilisation ci-dessous.

**Regroupez la prestation des soins**

Mettez en place des stratégies pour effectuer plusieurs tâches en utilisant les mêmes EPI. Exemple : prenez les signes vitaux et administrez les médicaments en même temps.

**Utilisez correctement les EPI**

L’OMS recommande l’utilisation d’un masque chirurgical pour les soins de routine aux patients susceptibles d’avoir le COVID, et l’utilisation de masques N95 pour les patients confirmés COVID pendant les procédures à risque de générer une aérosolisation, comme l’intubation ou la nébulisation. Dans la mesure du possible, les masques N95 doivent être remplacés après toute procédure susceptible de générer une aérosolisation, mais il peut s’avérer nécessaire de les réutiliser. Les masques N95 doivent être utilisés conformément aux protocoles PIH pour le traitement de la tuberculose.

**RÉUTILISATION DES EPI**

**Masques faciaux:** Les masques faciaux réutilisables peuvent être trempés dans une solution d’hypochlorite de sodium à 0,5 % pendant 1 heure, puis laissés à sécher dans un espace propre et ouvert pendant au moins 1 heure

**Blouses:** Dans certains services, les blouses doivent parfois être portées en continu pendant qu’un soignant s’occupe de plusieurs patients. Dans ces cas-là, le soignant doit superposer deux paires de gants et changer ceux du dessus entre les patients. Si peu de blouses sont disponibles, des blouses réutilisables peuvent être envisagées (voir les directives PIH sur les EPI alternatifs). Si des blouses réutilisables sont utilisées, elles doivent être lavées en machine à 60-90 °C avec un produit détergent.

**Masques chirurgicaux et procéduraux:** Compte tenu des niveaux mondiaux actuels d’approvisionnement, dans la plupart des hôpitaux une utilisation prolongée des masques sera nécessaire entre les patients (le masque n’est pas retiré d’un patient à l’autre, mais reste en permanence sur le visage du soignant). Dans de nombreux hôpitaux, les masques devront être réutilisés, c’est-à-dire qu’ils seront retirés du visage, puis remis entre les patients. PIH a mis à disposition un outil de travail expliquant comment réutiliser le masque en toute sécurité. Les principaux éléments de cet outil indiquent que:

- Chaque masque chirurgical et procédural doit être porté par une seule personne.
- Le masque retiré doit être placé dans un récipient désigné pour sa réutilisation.
- Procédez à l’hygiène des mains immédiatement avant et après avoir mis ou touché un masque réutilisé.
- Les masques doivent être remplacés lorsqu’ils sont sales ou contaminés.
**LIMITEZ AU MAXIMUM LE NOMBRE DE PERSONNES QUI UTILISENT DES EPI**

- **Lors des tournées de patients**
  Faites en sorte que seuls les soignants directs interagissent avec le patient, plutôt que les membres de l’équipe chargée des soins à d’autres patients.

- **Pendant les quarts de travail**
  Désignez un sous-groupe de soignants qui travailleront dans la zone d’isolement, plutôt qu’avoir un plus grand nombre de soignants circulant dans les deux zones. Tous les soignants peuvent adhérer aux stratégies précisées ci-dessus afin de réduire l’utilisation des EPI.

- **En salle d’opération**
  Limitez les opérations aux seules interventions essentielles et limitez le nombre d’observateurs et de personnel non essentiel, ce qui permettra de réduire le nombre d’EPI utilisés.

- **En général**

**RÔLE DE L’ADMINISTRATION DES HÔPITAUX**

L’administration hospitalière doit faire activement respecter les mesures de préservation des stocks d’EPI.

**Les stratégies utilisées comprennent:**

- Supprimer ou limiter les EPI dans les services moins susceptibles d’en avoir besoin.
- Organiser la distribution centralisée des EPI au lieu de les stocker dans les différents services.
- Un personnel dédié au contrôle des EPI afin de réajuster les procédures utilisées par certains soignants en cas de sur-utilisation des EPI (par exemple, si un masque N95 est utilisé dans une situation où un masque chirurgical aurait suffi).
Nuestra prioridad es la seguridad de nuestros pacientes y trabajadores de la salud. Es IMPRESCINDIBLE que a medida que los sistemas de triaje y aislamiento se planifican e implementan rápidamente, se realicen esfuerzos iniciales para conservar el EPP ya que el abastecimiento global es limitado. Conservar el EPP ahora garantizará suficientes suministros para mantener a los proveedores a salvo durante toda la pandemia.

**REDUZCA ESTRATÉGICAMENTE EL USO INDIVIDUAL DE EPP**

### Uso extendido y reutilización

Se prefiere el uso extendido sobre la reutilización. El uso extendido de protección respiratoria se define como el uso de una máscara desechable sin quitarse o volver a ponerse la máscara. Debido a la epidemia que evoluciona rápidamente y para garantizar la protección de los trabajadores de salud de primera línea, muchas organizaciones, incluidos los CDC, recomiendan su reutilización cuando sea necesario. Vea a continuación los procedimientos de reutilización segura.

### Entrega de atención concentrada

Desarrolle estrategias para completar múltiples tareas utilizando el mismo conjunto de PPE. Por ejemplo: tomar signos vitales y administrar medicamentos al mismo tiempo.

### Uso apropiado de PPE

La OMS recomienda el uso de una máscara quirúrgica para la atención rutinaria de pacientes con sospecha de COVID, y el uso de N95 en pacientes con COVID durante procedimientos de aerosolización como intubación o nebulización. Sin embargo, cuando se puedan reemplazar las máscaras N95 después de cualquier procedimiento de aerosolización, puede ser necesario reutilizar las máscaras N95. Las máscaras N95 deben usarse de acuerdo con los protocolos de PIH para el tratamiento de la TB+G2.

### REUTILICE LOS EPP

**Caretas:** Los protectores faciales reutilizables pueden empaparse en hipoclorito de sodio al 0,5% durante 1 hora y dejarse secar en un espacio limpio y abierto durante al menos 1 hora.

**Batas:** En algunas salas, es posible que sea necesario usar batas de manera continua a medida que el proveedor se mueve entre pacientes. En estos casos, el proveedor debe doblar los guantes y cambiar los guantes externos entre los pacientes. Si escasean las batas, se pueden considerar batas reutilizables. (Consulte las pautas de PIH sobre EPP alternativo). Si se usan batas reutilizables, se deben lavar a máquina con agua a 60-90° C y detergente para la ropa.

**Máscaras quirúrgicas y de procedimiento:** Dados los niveles globales de suministro actuales, la mayoría de los hospitales necesitarán un uso extendido de máscaras entre pacientes (lo que significa que la máscara no se quita entre pacientes sino que permanece en la cara de un proveedor continuamente). En muchos hospitales, las máscaras deberán reutilizarse (es decir, quitarla de la cara y luego volver a colocarla entre paciente y paciente). PIH tiene una ayuda laboral para ayudar con la reutilización segura de la máscara. Entre los usuarios y elementos clave incluimos:

- Las máscaras quirúrgicas y de procedimiento deben ser usadas por un solo usuario.
- La máscara retirada debe colocarse en un recipiente designado para su reutilización.
- Higienícese de las manos inmediatamente antes y después de ponerse o tocar una máscara reutilizada.
- Las máscaras deben reemplazarse cuando estén sucias o contaminadas.
MINIMIZAR EL NÚMERO DE PERSONAS QUE USAN EPP

- **En rondas de pacientes**: Considere solo que los cuidadores directos interactúen con el paciente en lugar de los miembros del equipo responsable del cuidado de otros pacientes.

- **En el turno**: Designe un subconjunto de cuidadores para operar en el área de aislamiento, en lugar de más proveedores en ambas áreas. Todos los cuidadores pueden adherirse a las estrategias anteriores para reducir el uso de EPP.

- **En la sala de operaciones**: Limite las cirugías a solo cirugías esenciales y limite el número de observadores y personal no esencial, reduciendo el número de conjuntos de EPP utilizados.

- **En general**: No permitir visitas para pacientes sospechosos o confirmados de tener COVID-19 (con la excepción de los padres para los niños). Los visitantes no pueden ingresar a la sala de aislamiento COVID-19.

**PAPEL DE LOS ADMINISTRADORES DEL HOSPITAL**

La administración del hospital debe hacer cumplir activamente las medidas de conservación del EPP. 

**Algunas estrategias pueden ser:**
- Removing or limiting PPE on wards less likely to require them
- Centralized PPE distribution instead of PPE stored on wards
- PPE monitors who can correct individuals when PPE is overused (for example, if an N95 mask is used in a situation where a surgical mask would have been sufficient)
PIH guide to extended use and reuse of masks and eye protection

During the COVID pandemic, extended use (when the mask or eye protection is worn continuously and not taken off between patients) or reuse (when the mask or eye protection is removed and then replaced) of personal protective equipment may be required.

In general:
- *Keep your mask on continuously as much as possible!* Extended use is preferred over reuse because there is less risk of spreading the virus.
- *You can never do hand hygiene enough!* Remember hand hygiene before and after removing or replacing any PPE item.
- *If you need to take your mask off, take it all the way off.* For example, do not pull a mask down under your chin to take a drink of water. This keeps your face from being accidently contaminated by the outside of the mask.

How to remove a mask:
- Perform hand hygiene
- Remove mask carefully by the straps. Do not touch the outside surface (dirty surface).
- Place the mask in your designated storage container – ensure you always place the dirty side (the outside of the mask) in the same direction
- Perform hand hygiene

How to put a used mask back on:
- Perform hand hygiene and put on gloves
- Carefully pick the mask up by the straps, and ensuring the outside does not touch your nose or mouth, replace it on your face
- Remove gloves and perform hand hygiene
- Only re-use your own mask

When to replace a mask for a new one:
- If it is wet or dirty
- If it is damaged
- If it has been used in an aerosol generating procedure, such as intubation, nebulization, or suctioning (for N95s)

When do I need an N95 instead of a surgical mask:
- When swabbing a patient for a COVID test (extended use or reuse ok)
• When performing an aerosol generating procedure, such as intubation, nebulization, or suctioning (discard after the procedure)

How to remove and reuse eye protection:
• Remove eye protection by the handles of the goggles or strap of the face shield. Carefully place outside down (dirty side down) in a ‘dirty bin.’
• Perform hand hygiene. Then either:
  o Option 1: Put on new gloves. Clean all sides of the eye protection with the cleaning solution. Place the eye protection into your own designated storage container (separate from your mask), dirty side (outside down). Remove gloves and perform hand hygiene.
  o Option 2: Reusable eye protection may be soaked in sodium hypochlorite 0.5% for 1 hour and left in a clean, open space to dry for at least 1 hour.
Extended Use PPE – Donning

1. Don PPE outside of patients room. Ensure hair is pulled back away from face.
2. Perform hand hygiene with alcohol-based sanitizer OR soap and water.
3. Put on gown.
   - Ensure gown fully covers entire body when closed or tied.
4. Put on mask/respirator.
   - If new mask/respirator, hold mask/respirator in one hand and bring to face.
   - Pull lower elastic band over head and below ears.
   - Pull upper elastic band over head and allow ears.
   - Press nose clip to ensure a tight seal of mask.
5. Perform hand hygiene.
6. Put on gloves.
   - Ensure gloves go over cuff of gown.
   - If using same gown between patients, put 2 pairs of gloves on. Change external pair between each patient.

Annex

STOP COVID Partners In Health

Updated 17 June 2020
Extended Use PPE — Doffing

1. Doff PPE, except for mask/respirator in patient’s room/ward. Remember gloves, face shield, front of gown and sleeves are CONTAMINATED. Wash hands immediately if you touch any of these surfaces with your bare hands.

2. Remove gown
   - Avoid touching outside contaminated surface of gown
   - Pull gown from head and away from body
   - If possible, remove gloves at same time as gown, ensuring you only touch the inside of gown and gloves
   - Wrap gown into a ball with contaminated surface (outside of gown) inside
   - Discard gown in appropriate receptacle

3. If gloves removed, perform hand hygiene
   - Alcohol-based hand sanitizer

4. If not already done, remove gloves
   - Grasp gloves in palm of hand and pull glove off
   - Discard glove in waste container
   - Slowly and gently slide finger under other glove between glove and cuff of gown
   - Avoid touching contaminated side of glove

5. Perform hand hygiene
   - Alcohol-based hand sanitizer

6. Remove eye protection
   - If using face shield, tilt head forward, grasp strap and gently pull strap over head, pulling the face shield away from face
   - If using goggles, grasp ear pieces behind ears and pull goggles and away from face
   - Carefully place outside down (dirty side down) in a ‘dirty bin’ until they can be cleaned for re-use (see instructions on re-using PPE)

7. Perform hand hygiene
   - Alcohol-based hand sanitizer

8. With mask/respirator in place, leave patient’s room and enter anteroom or hallway

9. Remove mask/respirator
   - Pull lower elastic band over head
   - Pull upper elastic band over head and pull mask away from face
   - If reusing, place mask/respirator in an appropriate storage container (plastic container recommended). Ensure dirty side of mask/respirator is face down

10. Perform hand hygiene
    - Alcohol-based hand sanitizer
Guidance on Non-Standard PPE for COVID-19

The global COVID-19 pandemic has led to worldwide shortages of personal protective equipment (PPE). This document discusses alternative non-standard PPE that can be considered. It is important to note that, at present, none of the options below have sufficient evidence to recommend their routine use. First steps to expand PPE availability should be PPE conservation which includes extended use, re-use, and limiting the number of people and procedures that would require PPE. Please see PPE conservation guidance. The use of non-standard PPE should be used as a ‘last resort’ strategy. The strategies below are unproven and their ability to protect a healthcare worker is unknown.

Non-standard Mask Options
- Locally made cloth masks
  - Should be worn with face shield that extends to the chin or below for added protection
  - To increase effectiveness, masks should be made with tightly-woven, fluid-resistant fabric and fit closely to the face, over both the nose and mouth
  - Effectiveness may decrease when wet; should be replaced if sweaty or damp
  - It should be noted multiple studies show these do not provide as much protection as official surgical masks and they should only be worn as last resort. One study suggests an increased infection risk and a false sense of protection for clinicians.
  - During this time of global shortage there are some institutions that are prioritizing the use of cloth masks in low-risk areas to conserve the use of surgical masks and N95s to higher risk and known risk patient areas.
  - Makeshift ‘respirators’ from surgical masks and viral filters are being researched as alternate N95s in aerosolizing procedures
  - Multiple organizations are researching options to sterilize single use masks, but no standards have emerged yet. More information on this may be available in coming weeks.

Non-standard gown options
- Locally made gowns can be considered in the absence of certified gowns. There is limited data on these.
  - Should be made of cloth with small pore size: non-woven, spun bound fabric, or tightly-woven, fluid-resistant fabric (such as polyester)
  - Certified re-usable gowns are typically coated with a fluorocarbon-based repellant finish to prevent liquid and microbial penetration. This may not be possible with local gowns, so particular care should be taken to avoid getting gowns wet and to change when wet.
  - Design:
- Extends to knees; fully covers arms and torso (front as one piece and back with ties)
- Cuffs at end of arms (consider thumb loops to prevent gap between gown and gloves)
- Higher neck to protect against splashes
- Tight-seams or sealed seems
- Inspect with each use to ensure no visible holes
- Clothes worn underneath a locally made gown should be inspected after doffing – if soiled, they must be properly sterilized or discarded
- Other gown alternatives include lab coats, patient gowns, aprons, combinations of clothing (sleeve covers + coats) and should be used as a last resort.
1 CONFIRMED WARD - EQUIPMENT
SCALE 1 : 100

2 PRESUMPTIVE WARD - EQUIPMENT
SCALE 1 : 100

FLOOR PLANS
SK02

Draft- For Review
1 CONFIRMED WARD
SCALE 1 : 100

2 PRESUMPTIVE WARD
SCALE 1 : 100

Draft- For Review
1 PRESUMPTIVE WARD

SCALE 1 : 50

2 CONFIRMED WARD

SCALE 1 : 50
1. **PRESUMPTIVE WARD NORTH**  
   **SCALE 1:100**

2. **PRESUMPTIVE WARD EAST**  
   **SCALE 1:100**

3. **PRESUMPTIVE WARD SOUTH**  
   **SCALE 1:100**

4. **PRESUMPTIVE WARD WEST**  
   **SCALE 1:100**

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**STOP COVID**  
**Partners In Health**

SK07  
ELEVATIONS PRESUMPTIVE WARD
1 3D AXON PRESUMPTIVE WARD

2 3D AXON CONFIRMED WARD
FRAMED PLYWOOD WALLS

- 4" CONCRETE SLAB
- 2X4 STUD WALL @ 24" OC
- CONT 6 MIL WHITE PLASTIC SHEET INTERIOR
- EXPANDING CONCRETE ANCHOR ATTACHMENT

FRAMED PLYWOOD WALLS @ WINDOWS

- 1/2" CDX PLYWOOD OR 7/16" OSB SHEATHING
- 2X4 STUD WALL @ 24" OC
- CONT 6 MIL WHITE PLASTIC SHEET INTERIOR
- EXPANDING CONCRETE ANCHOR ATTACHMENT

CORRUGATED METAL ROOFING
- 2X2 STEEL PURLINS PER STRUCTURAL DETAIL
- INSULATION B/W PURLINS & METAL ROOFING
- STEEL TRUSS ROOF FRAME - SEE DETAIL
- DOUBLE TOP PLATE
- CONT 6 MIL WHITE PLASTIC SHEET - STAPLE TO INTERIOR OF WALLS

4" CONCRETE SLAB

- 0.102 m
- 0' - 4"

- 0.152 m
- 0' - 6"

- 0.914 m
- 3' - 0"

- 1/4" ALL-THREAD OR #2 OR #3 REBAR STITCHED ONTO BOTTOM EDGE OF TARP

TIE STRIPS TO HOLD TARP IN ROLLED UP POSITION
NAIL TOP OF TARP TO BUILDING
WALL OPENING
OUTLINE OF ROLL-UP TARP (3" LARGER THAN OPENING ON EACH SIDE)
OUTLINE OF SCREEN NAILED TO WALL (1" LARGER THAN OPENING ON EACH SIDE)

SCREEN NAILED ONTO EXTERIOR WALL OF BUILDING

3' - 0"

ROLL-UP TARP NAILED AT TOP. SEE ELEVATION DETAIL
SCREEN NAILED ONTO EXTERIOR WALL OF BUILDING

CONT 6 MIL WHITE PLASTIC SHEET - STAPLE TO INTERIOR OF WALLS

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PARTNERS IN HEALTH

SK09
WALL SECTIONS

WINDOW COVERING ELEVATION

WALL SECTIONS
SK09
Draft- For Review
FLOOR DRAIN LINE TO RUN TO EXTERIOR WALL AND EMPTY ONTO GROUND
OSB/ PLYWOOD WALL PANEL SINK BACKING
EXTERIOR WALL
WALL MOUNTED SINK
ROCK PILE AT DRIP LOCATION. GRADE SLOPES AWAY FROM BUILDING
FLOOR

OPTION A: PLUMBED SINK

BUCKET W/ SPOUT
BUCKET/ BASIN - DUMP OUTSIDE TO DRAIN
WALL BRACKET TO HOLD BUCKETS
EXTERIOR WALL
FLOOR

OPTION B: BUCKET SINK

SINK OPTION DETAILS
NOTES:
1. TRUSS SPACING TO BE 10'-0" OC (7 TRUSSES PER 60' BUILDING)
2. PURLINS TO EXTEND 18" BEYOND BUILDING ENDS, PROVIDE 2x4x3/16 HSS END FRAME
3. ALL CONNECTIONS TO BE WELDED
WOOD TRUSS DETAILS

SK12

PENDING STRUCTURAL DESIGN

Draft- For Review

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SK12 WOOD TRUSS DETAILS
Typical Ward Electrical Power Plan

Version 1.02-IEC
Recommended Earthing System
TN-C-S

Typical Ward Panel Schedule

<table>
<thead>
<tr>
<th>DIRECTORY</th>
<th>L1</th>
<th>L2</th>
<th>Ckt.</th>
<th>AMPS</th>
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<td>2</td>
<td>10/1 RCBO</td>
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<td>E Spare</td>
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RCPT: 1ST 10KVA @ 100% = 4,320 VA
Remaining KVA @ 50% = 0 VA
LIGHTING: KVA @ 100% = 916 VA
EQUIP: KVA @ 100% = 2
TOTAL DEMAND = 5,236 VA
TOTAL AMPS = 23.8 AMPS

ELECTRICAL INSTALLATION GENERAL NOTES

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