

## Definition of a Person Under Investigation (PUI)\*

Report suspect PUIs to the KDHE Epidemiology Hotline by filling out and faxing [a form](#) to 877-427-7318

Epidemiologic Risk	&	Clinical Features
Close contact <sup>^</sup> with a person that has laboratory-confirmed COVID-19 and developed symptoms within 14 days of contact	AND	Measured fever above 100°F <b>or</b> lower respiratory illness (cough or shortness of breath)
History of travel outside of Kansas within 14 days of symptom onset	AND	Measured fever above 100°F <b>and</b> lower respiratory symptoms (cough or shortness of breath) <b>and</b> other respiratory tests were performed and are negative
No source of exposure has been identified		
Kansas resident in a county with sustained community transmission*	AND	Severe respiratory illness <b>and</b> hospitalized <b>and</b> other respiratory tests were performed and are negative

<sup>^</sup>Being within 6 feet for a prolonged period (10 minutes or longer) or having direct contact with infectious secretions of a COVID-19 case (e.g. being coughed on)

\*Currently this only includes Johnson County

Diagnostic testing for COVID-19 is now available through LabCorp, Mayo Clinic Laboratories, Quest Diagnostics, and Viracor. Testing through KHEL **must** be approved by KDHE. Fill out a [testing approval form](#), fax to 877-427-7318, and include a copy with the specimen.

### Information to Gather for the Call to the KDHE Epidemiology Hotline

This will help our team determine if the patient meets the definition of a PUI and needs to be tested.

Detailed information is key for PUI determination.

Patient name: \_\_\_\_\_ Patient date of birth: \_\_\_\_\_

Patient address: \_\_\_\_\_

Patient phone: \_\_\_\_\_

Provider/caller name: \_\_\_\_\_

Provider/caller phone: \_\_\_\_\_

Provider/caller affiliated organization: \_\_\_\_\_

## Travel History—both within and outside of the US

Asymptomatic: any within the past 14 days

Symptomatic: within 14 days prior to symptom onset

### Country/State/City

### Dates


### Exposure History

In the last 14 days, did the patient have close contact (within 6 ft. for  $\geq 10$  mins.) with a known or suspected COVID-19 case?

Yes     No     Unknown

In the last 14 days, did the patient have close contact with someone who has a recent travel history to a country of known transmission and became ill?

Yes     No     Unknown

### Clinical History

Does/has the patient had a fever?

Yes     No     Unknown

Were fever reducing meds used prior to patient presentation?

If yes;    Onset date:

Measured (i.e.  $\geq 100.4^\circ$  F):

Subjective:  "Feeling feverish"

If yes; when was last dose:

Chills     Sweating     Other:

Does the patient have any of the following signs/symptoms?

Cough     Shortness of breath  
 Fatigue     Chills     Runny nose  
 Congestion     Other: \_\_\_\_\_

Earliest onset date:

## Clinical History (cont.)

Did the patient have a chest x-ray?	<input type="checkbox"/> Not performed <input type="checkbox"/> Pending <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other:  Date performed: _____
Did the patient have a rapid influenza test?	<input type="checkbox"/> Not performed <input type="checkbox"/> Pending <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Did the patient have a respiratory panel test?	<input type="checkbox"/> Not performed <input type="checkbox"/> Pending <input type="checkbox"/> Negative <input type="checkbox"/> Positive for:  Date performed: _____
Do you anticipate that this patient will require admission to the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown