GREENCITY MEDICAL CENTER

*One with nature in bringing quality healthcare*

# COVID -19 RT PCR REQUEST FORM

**Reason for the Test (Choose one):**

☐ OFW/Flight ☐ Medical ☐ Employment ☐ In-Patient/OPD ☐ Others: _____
please specify

**Name of Patient (Enter only one letter/character per box using CAPITAL LETTERS – SURNAME, FIRST NAME, MIDDLE NAME):**

**LAST NAME** | **FIRST NAME (Jr., Sr., II, III)**

**MIDDLE NAME** | **Place of Birth**

**Civil Status (PSA Based):** ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced

**Employment Status:** ☐ Employed ☐ Unemployed **Company Name:** _____

**Registered Address (House #, Street, Barangay, Municipality/City, Province – place space/comma after each entry):**

**HOUSE#** | **STREET** | **BARANGAY**

**MUNICIPALITY/CITY** | **PROVINCE**

**REGION (I, II, III, etc.)** | **NATIONALITY** | **Email Address**

**Contact Number:** +63 – | **Alternate Contact Number:** +63 –

**Date of Birth (mm/dd/yyyy):** / / | **Age (in yrs):** | **Sex (M/F):** | **Passport#:**

**For OFW or those with flight schedules, kindly complete the data below:**

**Flight Date (mm/dd/yyyy):** / / | **Time (hh:mm/AM or PM):** : : / | **Flight No.:**

**Requested Result Release Date (mm/dd/yyyy):** / / | **Requested Release Time (hh:mm/AM or PM)** : / | **Name of Airline:** _____

**Name of Requesting Physician:** _____

**Symptoms:** _____

_____

*I hereby declare that all information stated herein are TRUE to the best of my knowledge and belief.*

_____
Signature of Patient over Printed Name/Date

---

***For hospital personnel only, please do not fill up.***

**Type of Specimen:**

( ) Oropharygeal / Nasopharygeal Swab
( ) Sputum
( ) Brocho-alveolar Lavage
( ) Others, specify : _____

Date collected (MM/DD/YY): _____
Time Collected: _____(AM/PM)
Date of sample receipt: _____

**HOSPITAL / LABORATORY INFORMATION**

Laboratory / Hospital Name: _____
Address: _____
Contact Number: _____ Email Address: _____
Specimen Checked and Validated by: _____
Printed name over Signature of Hospital Staff

**Cont. of Exposure History List of Close Contacts**

| | Name | Contact number |
|---|---|---|
| List the names of persons who were with you during this (these) occasion(s) and their contact numbers: *Use the back part of this sheet when needed* | 1. | |
| | 2. | |
| | 3. | |
| | 4. | |
| | 5. | |
| | 6. | |
| | 7. | |
| | 8. | |
| | 9. | |
| | 10. | |
| | 11. | |
| | 12. | |
| | 13. | |
| | 14. | |
| | 15. | |
| | 16. | |
| | 17. | |
| | 18. | |
| | 19. | |
| | 20. | |

**COVID-19 Case Definitions:**

1. **Suspect case** –is a person who is presenting with any of the conditions below.
   a. All SARI cases where NO other etiology fully explains the clinical presentation.
   b. ILI cases with any one of the following:
      i. with no other etiology that fully explains the clinical presentation AND a history of travel to or residence in an area that reported local transmission of COVID-19 disease during the 14 days prior to symptom onset OR
      ii. with contact to a confirmed or probable case of COVID-19 in the two days prior to onset of illness of the probable/confirmed COVID-19 case until the time the probable/confirmed COVID-19 case became negative on repeat testing.
   c. Individuals with fever or cough or shortness of breath or other respiratory signs or symptoms fulfilling any one of the following conditions:
      i. Aged 60 years and above
      ii. With a comorbidity
      iii. Assessed as having a high-risk pregnancy
      iv. Health worker
2. **Probable case** – a suspect case who fulfills anyone of the following listed below.
   a. Suspect case whom testing for COVID-19 is inconclusive
   b. Suspect who tested positive for COVID-19 but whose test was not conducted in a national or subnational reference laboratory or officially accredited laboratory for COVID-19 confirmatorytesting
3. **Confirmed case** – any individual, irrespective of presence or absence of clinical signs and symptoms, who was laboratory confirmed for COVID-19 in a test conducted at the national reference laboratory, a subnational reference laboratory, and/or DOH-certified laboratory testing facility.

GREENCITY MEDICAL CENTER
*One with nature in bringing quality healthcare*

**WAIVER OF DATA PRIVACY CONSENT/ AGREEMENT**

I_____ of legal age, Filipino married/single and a resident of _____ do hereby state:

1.] That I conform and agree that GREENCITY MEDICAL CENTER recognizes its responsibilities under the Republic Act No. 10173 (Act), also known as the Data Privacy Act of 2012, with respect to the data they collect, record, organize, update, use, and consolidate from me;

2.] That I hereby acknowledge that the personal data and result of my COVID 19 test obtained by GREENCITY MEDICAL CENTER is entered and stored within the hospital's authorized information and communications system and will only be accessed by the GreenCity Medical Center, the Department of Health (DOH) and the Municipality and Local Government of Pampanga and other concerned agencies and entities;

3.] That I hereby agree and give my full, free and voluntary consent that the information collected and stored in the portal shall only be used by GreenCity Medical Center, the Department of Health (DOH) and the Municipality and Local Government of Pampanga and other concerned agencies for the following purposes:

1. Processing and reporting of patients data and results related to the COVID-19 RT PCR test.
2. Announcements of health programs and courses to prevent the spread of the disease; and
3. Other activities organized by the Department of Health and the Local Government Unit;

4.] **That while waiting for the confirmatory result for the presence of COVID 19 disease by GREENCITY MEDICAL CENTER, I hereby undertake to do a HOME QUARANTINE for the next 14 days or if required, quarantine myself in any government facilities and/or isolate myself from any person to prevent infecting other people; and that according to government regulations, those who did not underwent self quarantine will be held liable if the result turns positive.**

5.] That I hereby release GREENCITY MEDICAL CENTER, its officers, directors, stockholders, employees and other personnel from any liabilities from the information revealed and disclosed in relation to the test and result that was conducted upon me to the Department of Health, the Municipal & Local Government Unit or to any concerned agencies or persons;

6. ] That I have read the hospital's Data Privacy Statement and express my consent in favor of the Hospital to collect, record, organize, update or modify, retrieve, consult, use, consolidate, block, erase or destruct my personal data as part of my information. P
Pursuant to the provisions of the Republic Act No. 10173 of the Philippines, Data Privacy Act of 2012 and its corresponding Implementing Rules and Regulations.

City of San Fernando, Pampanga _____2020

_____
NAME OF PATIENT

WITNESSED BY

_____ _____

Philippine Integrated Disease Surveillance and Response

# Case Investigation Form
# Coronavirus Disease (COVID-19)
Version 9

1) The Case Investigation Form (CIF) is meant to be administered as an interview by a health care worker or any personnel of the DRU. **This is not a self-administered questionnaire**.
2) Please be advised that DRUs are only allowed to obtain **1 copy of accomplished CIF** from a patient.
3) Please fill out all blanks and put a check mark on the appropriate box. Never leave an item blank (write N/A). **Items with * are required fields**. All dates must be in **MM/DD/YYYY format**.

| Disease Reporting Unit* | DRU Region and Province | PhilHealth No.* |
|---|---|---|
| | | |
| **Name of Interviewer** | **Contact Number of Interviewer** | **Date of Interview *(MM/DD/YYYY)**** |
| | | |
| **Name of Informant *(if applicable)*** | **Relationship** | **Contact Number of Informant** |
| | | |

| | | | |
|---|---|---|---|
| If existing case (*check all that apply*)* | ☐ Not applicable (New case) | ☐ Update case classification | ☐ Update disposition |
| | ☐ Not applicable (Unknown) | ☐ Update vaccination | ☐ Update exposure / travel history |
| | ☐ Update symptoms | ☐ Update lab result | ☐ Others, specify: |
| | ☐ Update health status / outcome | ☐ Update chest imaging findings | _____ |
| Type of Client* | ☐ COVID-19 Case (Suspect, Probable, or Confirmed) | ☐ Close Contact | ☐ For RT-PCR Testing (Not a Case of Close Contact) |
| **Testing Category/Subgroup*** *(Check all that apply, refer to Appendix 2)* | ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ I ☐ J | | |

## Part 1. Patient Information

### 1.1. Patient Profile

| Last Name* | First Name (and Suffix)* | Middle Name* | |
|---|---|---|---|
| Birthday (MM/DD/YYYY)* | Age* | Sex* ☐ Male | ☐ Female |
| Civil Status | Nationality* | | |
| Occupation | Works in a closed setting? ☐ Yes | ☐ No | ☐ Unknown |

### 1.2. Current Address in the Philippines and Contact Information* *(Provide address of institution if patient lives in closed settings, see 1.5)*

| House No./Lot/Bldg.* | Street/Purok/Sitio* | Barangay* | Municipality/City* |
|---|---|---|---|
| | | | |
| **Province*** | **Home Phone No. (& Area Code)** | **Cellphone No.*** | **Email Address** |
| | | | |

### 1.3. Permanent Address and Contact Information *(if different from current address)*

| House No./Lot/Bldg. | Street/Purok/Sitio | Barangay | Municipality/City |
|---|---|---|---|
| | | | |
| **Province** | **Home Phone No. (& Area Code)** | **Cellphone No.** | **Email Address** |
| | | | |

### 1.4. Current Workplace Address and Contact Information

| Lot/Bldg. | Street | Barangay | Municipality/City |
|---|---|---|---|
| | | | |
| **Province** | **Name of Workplace** | **Phone No./Cellphone No.** | **Email Address** |
| | | | |

### 1.5. Special Population *(indicate further details on exposure and travel history in Part 3)*

| | | |
|---|---|---|
| Health Care Worker* | ☐ Yes, name of health facility:_____ and location: _____ | ☐ No |
| Returning Overseas Filipino* | ☐ Yes, country of origin: _____ and Passport number: _____<br>OFW: ☐ OFW ☐ Non-OFW | ☐ No |
| Foreign National Traveler* | ☐ Yes, country of origin: _____ and Passport number: _____ | ☐ No |
| Locally Stranded Individual / APOR / Local Traveler* | ☐ Yes, City, Municipality, & Province of origin _____<br>☐ Locally Stranded Individual ☐ Authorized Person Outside Residence / Local Traveler | ☐ No |
| Lives in Closed Settings* | ☐ Yes, institution type: _____ and name: _____<br>*(e.g. prisons, residential facilities, retirement communities, care homes, camps, etc.)* | ☐ No |

## Part 2. Case Investigation Details

### 2.1. Consultation Information

| | | |
|---|---|---|
| Have previous COVID-19 related consultation? | ☐ Yes, Date of First Consult *(MM/DD/YYYY)** _____ | ☐ No |
| Name of facility where first consult was done | | |

### 2.2. Disposition at Time of Report* (Provide name of hospital/isolation/quarantine facility)

| | |
|---|---|
| ☐ Admitted in hospital _____ | Date and Time admitted in hospital _____ |
| ☐ Admitted in isolation/quarantine facility _____ | Date and Time isolated/quarantined in facility _____ |
| ☐ In home isolation/quarantine | Date and Time isolated/quarantined at home _____ |
| ☐ Discharged to home | If discharged: Date of Discharge *(MM/DD/YYYY)** _____ ☐ Others: _____ |

| | | | | | |
|---|---|---|---|---|---|
| **2.3. Health Status at Consult* (*Refer to Appendix 3*)** | ☐ Asymptomatic | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Critical |
| **2.4. Case Classification* (*Refer to Appendix 1*)** | ☐ Suspect | ☐ Probable | ☐ Confirmed | ☐ Non-COVID-19 Case | |

### 2.5. Vaccination information*

| Date of vaccination* | Name of Vaccine* | Dose number (e.g. 1st, 2nd)* | Vaccination center/facility | Region of health facility | Adverse event/s? |
|---|---|---|---|---|---|
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |



Clear All Fields

**2.6. Clinical Information**

Date of Onset of Illness *(MM/DD/YYYY)** _____

Signs and Symptoms *(Check all that apply)*

| | |
|---|---|
| ☐ Asymptomatic | ☐ Dyspnea |
| ☐ Fever _____ °C | ☐ Anorexia |
| ☐ Cough | ☐ Nausea |
| ☐ General weakness | ☐ Vomiting |
| ☐ Fatigue | ☐ Diarrhea |
| ☐ Headache | ☐ Altered Mental Status |
| ☐ Myalgia | ☐ Anosmia (loss of smell, w/o any identified cause) |
| ☐ Sore throat | ☐ Ageusia (loss of taste, w/o any identified cause) |
| ☐ Coryza | ☐ Others, specify_____ |

Comorbidities *(Check all that apply if present)*

| | |
|---|---|
| ☐ None | ☐ Gastrointestinal |
| ☐ Hypertension | ☐ Genito-urinary |
| ☐ Diabetes | ☐ Neurological Disease |
| ☐ Heart Disease | ☐ Cancer |
| ☐ Lung Disease | ☐ Others _____ |

| | | |
|---|---|---|
| Pregnant? | ☐ Yes, LMP *(MM/DD/YYYY)* _____ | ☐ No |
| High-risk pregnancy? | ☐ Yes | ☐ No |
| Was diagnosed to have Severe Acute Respiratory Illness? | ☐ Yes | ☐ No |

Chest imaging findings suggestive of COVID-19

| Date done | Chest imaging done | Results |
|---|---|---|
| | ☐ Chest radiography<br>☐ Chest CT<br>☐ Lung ultrasound<br>☐ None | ☐ Normal<br>☐ Pending<br>☐ Chest radiography: Hazy opacities, often rounded in morphology, with peripheral and lower lung dist.<br>☐ Chest CT: Multiple bilateral ground glass opacities, often rounded in morphology, w/ peripheral & lower lung dist.<br>☐ Lung ultrasound: Thickened pleural lines, B lines, consolidative patterns with or without air bronchograms<br>☐ Other findings, specify _____ |

**2.7. Laboratory Information**

Have tested positive using RT-PCR before? * ☐ Yes, date of specimen Collection *(MM/DD/YYYY)** _____ ☐ No

Laboratory* _____ No. of previous RT-PCR swabs done ____

| Date collected* | Date released | Laboratory* | Type of test* | Results* |
|---|---|---|---|---|
| | | | ☐ RT-PCR (OPS) ☐ Antigen; reason_____<br>☐ RT-PCR (NPS) brand of kit _____<br>☐ RT-PCR (OPS and NPS) ☐ Antibody Test<br>☐ Others: _____ | ☐ Pending ☐ Negative<br>☐ Positive ☐ Equivocal<br>☐ Others: |
| | | | ☐ RT-PCR (OPS) ☐ Antigen; reason_____<br>☐ RT-PCR (NPS) brand of kit _____<br>☐ RT-PCR (OPS and NPS) ☐ Antibody Test<br>☐ Others: _____ | ☐ Pending ☐ Negative<br>☐ Positive ☐ Equivocal<br>☐ Others: |

**2.8. Outcome/Condition at Time of Report***

☐ Active (currently admitted/isolation/quarantine) ☐ Recovered, date of recovery *(MM/DD/YYYY)** _____ ☐ Died, date of death *(MM/DD/YYYY)** _____

| | | |
|---|---|---|
| If died, cause of death* | Immediate Cause: | Antecedent Cause: |
| | Underlying Cause: | Contributory Conditions: |

**PART 3. Contact Tracing: Exposure and Travel History**

History of exposure to known probable and/or confirmed COVID-19 case 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection? * ☐ Yes, date of last contact *(MM/DD/YYYY)** _____ ☐ No ☐ Unknown

Has the patient been in a place with a known COVID-19 transmission 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection? * ☐ Yes, International ☐ Yes, Local ☐ No ☐ Unknown exposure

| | | | |
|---|---|---|---|
| If International Travel, country of origin | | Inclusive travel dates: | From: To: |
| | | With ongoing COVID-19 community transmission? | ☐ Yes ☐ No |

| Airline/Sea vessel | Flight/Vessel Number | Date of departure *(MM/DD/YYYY)* | Date of arrival in PH *(MM/DD/YYYY)* |
|---|---|---|---|
| | | | |

If Local Travel, specify travel places *(Check all that apply, provide name of facility, address, and inclusive travel dates in MM/DD/YYYY)*

| Place Visited | Name of Place | Address *(Region, Province, Municipality/City)* | Inclusive Travel Dates From: | Inclusive Travel Dates To: | With ongoing COVID-19 Community Transmission? |
|---|---|---|---|---|---|
| ☐ Health Facility | | | | | ☐ Yes ☐ No |
| ☐ Closed Settings | | | | | ☐ Yes ☐ No |
| ☐ School | | | | | ☐ Yes ☐ No |
| ☐ Workplace | | | | | ☐ Yes ☐ No |
| ☐ Market | | | | | ☐ Yes ☐ No |
| ☐ Social Gathering | | | | | ☐ Yes ☐ No |
| ☐ Others | | | | | ☐ Yes ☐ No |

☐ Transport Service, specify the following:

| Airline / Sea vessel / Bus line / Train | Flight / Vessel / Bus No. | Place of Origin | Departure Date *(MM/DD/YYYY)* | Destination | Date of Arrival *(MM/DD/YYYY)* |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

| | Name (*Use the back page if needed*) | Contact Number |
|---|---|---|
| - If symptomatic, provide names and contact numbers of persons who were with the patient two days prior to onset of illness until this date<br>- If asymptomatic, provide names and contact numbers of persons who were with the patient on the day specimen was submitted for testing until this date | | |
| | | |
| | | |
| | | |



Clear All Fields

**Appendix 1. COVID-19 Case Definitions**

| SUSPECT | PROBABLE |
|---|---|
| A) A person who meets the **clinical AND epidemiological criteria**<br>– **Clinical criteria:**<br>1) Acute onset of fever AND cough **OR**<br>2) Acute onset of **ANY THREE OR MORE** of the following signs or symptoms; fever, cough, general weakness/fatigue, headache, myalgia, sore throat, coryza, dyspnea, anorexia / nausea/ vomiting, diarrhea, altered mental status. **AND**<br>– **Epidemiological criteria**<br>1) Residing/working in an area with high risk of transmission of the virus (e.g closed residential settings and humanitarian settings, such as camp and camp-like setting for displaced persons), any time w/in the 14 days prior to symptoms onset **OR**<br>2) Residing in or travel to an area with community transmission anytime w/in the 14 days prior to symptoms onset; **OR**<br>3) Working in health setting, including w/in the health facilities and w/in households, anytime w/in the 14 days prior to symptom onset; **OR**<br>B) A patient with **severe acute respiratory illness** (SARI: acute respiratory infection with history of fever or measured fever of ≥ 38°C; cough with onset w/in the last 10 days; and who requires hospitalization) | A) A **patient** who meets the **clinical criteria** (on the left) **AND is contact of a probable or confirmed case**, or **epidemiologically linked to a cluster of cases** which had had at least one confirmed identified within that cluster<br>B) A **suspect case** (on the left) with **chest imaging showing findings suggestive of COVID-19 disease**. Typical chest imaging findings include (Manna, 2020):<br>– Chest radiography: hazy opacities, often rounded in morphology, with peripheral and lower lung distribution<br>– Chest CT: multiple bilateral ground glass opacities, often rounded in morphology, with peripheral and lower lung distribution<br>– Lung ultrasound: thickened pleural lines, B lines (multifocal, discrete, or confluent), consolidative patterns with or without air bronchograms<br>C) A person with **recent onset of anosmia (loss of smell), ageusia (loss of taste) in the absence of any other identified cause**<br>D) Death, not otherwise explained, in an **adult with respiratory distress preceding death AND who was a contact of a probable or confirmed case or epidemiologically linked to a cluster** which has had at least one confirmed case identified with that cluster |
| | **CONFIRMED** |
| | A person with **laboratory confirmation of COVID-19 infection**, irrespective of clinical signs and symptoms. |

**Appendix 2. Testing Category / Subgroup**

| | |
|---|---|
| **A** | Individuals with **severe/critical** symptoms and **relevant history** of travel/contact |
| **B** | Individuals with **mild** symptoms, **relevant history** of travel/contact, and considered **vulnerable**; vulnerable populations include those elderly and with preexisting medical conditions that predispose them to severe presentation and complications of COVID-19 |
| **C** | Individuals with **mild** symptoms, and **relevant history** of travel and/or contact |
| **D** | Individuals with **no symptoms** but with **relevant history** of travel and/or contact or high risk of exposure. These include: |
| D1 | - **Contact-traced individuals** |
| D2 | - **Healthcare workers**, who shall be prioritized for regular testing in order to ensure the stability of our healthcare system |
| D3 | - **Returning Overseas Filipino** (ROF) workers, who shall immediately be tested at port of entry |
| D4 | - Filipino citizens in a specific locality within the Philippines who have expressed intention to return to their place of residence/home origin (**Locally Stranded Individuals**) may be tested subject to the existing protocols of the IATF |
| **E** | **Frontliners indirectly involved in health care provision** in the response against COVID-19 may be tested as follows: |
| E1 | Those with **high or direct exposure to COVID-19 regardless of location** may be tested up to once a week. These include: **(1)** Personnel manning the Temporary Treatment and Quarantine Facilities (LGU and Nationally-managed); **(2)** Personnel serving at the COVID-19 swabbing center; **(3)** Contact tracing personnel; and **(4)** Any personnel conducting swabbing for COVID-19 testing |
| E2 | Those who **do not have high or direct exposure to COVID-19** but who **live or work in Special Concern Areas** may be tested up to every two to four weeks. These include the following: **(1)** Personnel manning Quarantine Control Points, including those from Armed Forces of the Philippines, Bureau of Fire Protection; **(2)** National / Regional / Local Risk Reduction and Management Teams; **(3)** Officials from any local government / city / municipality health office (CEDSU, CESU, etc.); **(4)** Barangay Health Emergency Response Teams and barangay officials providing barangay border control and performing COVID-19-related tasks; **(5)** Personnel of Bureau of Corrections and Bureau of Jail Penology & Management; **(6)** Personnel manning the One-Stop-Shop in the Management of ROFs; **(7)** Border control or patrol officers, such as immigration officers and the Philippine Coast Guard; and **(8)** Social workers providing amelioration and relief assistance to communities and performing COVID-19-related tasks |
| **F** | Other **vulnerable patients** and those **living in confined spaces**. These include but are not limited to: **(1)** Pregnant patients who shall be tested during the peripartum period; **(2)** Dialysis patients; **(3)** Patients who are immunocompromised, such as those who have HIV/AIDS, inherited diseases that affect the immune system; **(4)** Patients undergoing chemotherapy or radiotherapy; **(5)** Patients who will undergo elective surgical procedures with high risk for transmission; **(6)** Any person who have had organ transplants, or have had bone marrow or stem cell transplant in the past 6 months; **(7)** Any person who is about to be admitted in enclosed institutions such as jails, penitentiaries, and mental institutions. |
| **G** | Residents, occupants or workers in a **localized area with an active COVID-19 cluster**, as identified and declared by the local chief executive in accordance with existing DOH Guidelines and consistent with the National Task Force Memorandum Circular No. 02 s.2020 or the Operational Guidelines on the Application of the Zoning Containment Strategy in the Localization of the National Action Plan Against COVID-19 Response. The local chief executive shall conduct the necessary testing in order to protect the broader community and critical economic activities and to avoid a declaration of a wider community quarantine. |
| **H** | Frontliners in **Tourist Zones**: |
| H1 | All workers and employees in the **hospitality and tourism sectors** in El Nido, Boracay, Coron, Panglao, Siargao and other tourist zones, as identified and declared by the Department of Tourism. These workers and employees may be tested once every four (4) weeks. |
| H2 | All **travelers**, whether of domestic or foreign origin, may be tested at least once, at their own expense, prior to entry into any designated tourist zone, as identified and declared by the Department of Tourism. |
| **I** | All workers and employees of **manufacturing companies and public service providers registered in economic zones** located in Special Concern Areas may be tested regularly. |
| **J** | **Economy Workers** |
| J1 | **Frontline and Economic Priority Workers**, defined as those 1) who work in high priority sectors, both public and private, 2) have high interaction with and exposure to the public, and 3) who live or work in Special Concerns Areas, may be tested every three (3) months. These include but not limited to:<br>- **Transport and Logistics**: drivers of taxis, ride hailing services, buses, public transport vehicle, conductors, pilots, flight attendants, flight engineers, rail operators, mechanics, servicemen, delivery staff, water transport workers (ferries, inter-island shipping, ports)<br>- **Food Retails**: waiters, waitress, bar attendants, baristas, chefs, cooks, restaurant managers<br>- **Education**: teachers at all levels of education and other school frontliners such as guidance counselors, librarians, cashiers<br>- **Financial Services**: bank tellers<br>- **Non-Food Retails**: cashiers, stock clerks, retail salespersons<br>- **Services:** hairdressers, barbers, manicurists, pedicurists, massage therapists, embalmers, morticians, undertakers, funeral directors, parking lot attendants, security guards, messengers<br>- **Construction**: construction workers including carpenters, stonemasons, electricians, painters, foremen, supervisors, civil engineers, structural engineers, construction managers, crane/tower operators, elevator installers, repairmen<br>- **Water Supply, Sewerage, Waster Management**: plumbers, recycling/ reclamation workers, garbage collectors, water/wastewater engineers, janitors, cleaners<br>- **Public Sector**: judges, courtroom clerks, staff and security, all national and local government employees rendering frontline services in special concern areas<br>- **Mass Media:** field reporters, photographers, cameramen |
| J2 | All employees **not covered above are not required to undergo testing but are encouraged to be tested every quarter**. Private sector employers are highly encouraged to send their employees for regular testing at the employers' expense in order to avoid lockdowns that may do more damage to their companies. |

**Appendix 3. Severity of the Disease**

| MILD | CRITICAL |
|---|---|
| Symptomatic patients presenting with fever, cough, fatigue, anorexia, myalgias; other non-specific symptoms such as sore throat, nasal congestion, headache, diarrhea, nausea and vomiting; loss of smell (anosmia) or loss of taste (ageusia) preceding the onset of respiratory symptoms with **NO signs of pneumonia or hypoxia** | Patients manifesting with acute respiratory distress syndrome, sepsis and/or septic shock:<br>1. **Acute Respiratory Distress Syndrome (ARDS)**<br>a. Patients with onset within 1 week of known clinical insult (pneumonia) or new or worsening respiratory symptoms, progressing infiltrates on chest X-ray or chest CT scan, with respiratory failure not fully explained by cardiac failure or fluid overload<br>2. **Sepsis**<br>a. Adults with life-threatening organ dysfunction caused by a dysregulated host response to suspected or proven infection. Signs of organ dysfunction include altered mental status, difficult or fast breathing, low oxygen saturation, reduced urine output, fast heart rate, weak pulse, cold extremities or low blood pressure, skin mottling, or laboratory evidence of coagulopathy, thrombocytopenia, acidosis, high lactate or hyperbilirubinemia<br>b. Children with suspected or proven infection and > 2 age-based systemic inflammatory response syndrome criteria (abnormal temperature [> 38.5 °C or < 36 °C); tachycardia for age or bradycardia for age if < 1year; tachypnea for age or need for mechanical ventilation; abnormal white blood cell count for age or > 10% bands), of which one must be abnormal temperature or white blood cell count.<br>3. **Septic Shock**<br>a. Adults with persistent hypotension despite volume resuscitation, requiring vasopressors to maintain MAP > 65 mmHg and serum lactate level >2mmol/L<br>b. Children with any hypotension (SBP < Sth centile or > 2 SD below normal for age) or two or three of the following: altered mental status; bradycardia or tachycardia (HR < 90 bpm or > 160 bpm in infants and heart rate < 70 bpm or > 150 bpm in children); prolonged capillary refill (> 2 sec) or weak pulse; fast breathing; mottled or cool skin or petechial or purpuric rash; high lactate; reduced urine output; hyperthermia or hypothermia. |
| **MODERATE** | |
| 1. Adolescent or adult with **clinical signs of non-severe pneumonia** (e.g. fever, cough, dyspnea, respiratory rate **(RR) = 21-30 breaths/minute**, peripheral capillary oxygen saturation (SpO2) >92% on room air)<br>2. Child with clinical signs of non-severe pneumonia (cough or difficulty of breathing and fast breathing [ < 2 months: > 60; 2-11 months: > 50; 1-5 years: > 40] and/or chest indrawing) | |
| **SEVERE** | |
| 1. Adolescent or adult with **clinical signs of severe pneumonia or severe acute** respiratory **infection** as follows: fever, cough, dyspnea, **RR>30 breaths/minute**, severe respiratory distress or SpO2 < 92% on room air<br>2. Child with clinical signs of pneumonia (cough or difficulty in breathing) plus at least one of the following:<br>a. Central cyanosis or SpO2 < 90%; severe **respiratory distress** (e.g. fast breathing, grunting, very severe chest indrawing); general danger sign: **inability to breastfeed or drink**, **lethargy or unconsciousness**, or convulsions.<br>b. **Fast breathing (in breaths/min): < 2 months: > 60; 2-11 months: > 50; 1-5 years: > 40.** | |