Connecticut Department of Public Health
COVID-19 Vaccine Breakthrough Case Report Form

Please complete this form for any Connecticut resident who has **SARS-CoV-2 RNA or antigen detection in a respiratory specimen collected ≥14 days after completing the primary series (i.e. final dose) of an FDA-authorized COVID-19 vaccine**. Fax completed form to the Connecticut Department of Public Health at **860-629-6962.**

Patient Name (Last, First) _____ **Age** _____ **Date of Birth** _____ **Gender** ☐ Male ☐ Female ☐ Unknown

Address (Street, City, State, Zip Code) _____ **Phone** _____

Race (check all that apply)
☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ Other specify: _____

Hispanic/Latino
☐ Yes ☐ No ☐ Unknown

Collection Date for Positive COVID-19 Test _____ **Testing Laboratory** _____ **Test Type** ☐ PCR ☐ Antigen

History of positive COVID-19 test less than 45 days prior to current positive test? ☐ Yes ☐ No ☐ Unknown

Vaccine (dose 1) Date: _____ Vaccine Product: _____ Lot Number (if known): _____

Vaccine (dose 2) Date: _____ Vaccine Product: _____ Lot Number (if known): _____

Housing/residency at time of diagnosis
- ☐ House/single family home
- ☐ Apartment
- ☐ Hotel/motel
- ☐ Long term care facility
- ☐ Nursing home/assisted living facility
- ☐ Acute care inpatient facility
- ☐ Rehabilitation facility
- ☐ Correctional facility
- ☐ Mobile home
- ☐ Group home
- ☐ Homeless shelter
- ☐ Car/Outside/location not meant for human habitation
- ☐ Unknown

Underlying Health Conditions
- ☐ Currently pregnant
- ☐ Diabetes mellitus
- ☐ Chronic kidney disease
- ☐ Chronic liver disease
- ☐ Autoimmune disease, specify _____
- ☐ Immunocompromised
- ☐ Systemic immunosuppressive therapy/medications, specify _____

Immunocompromising Condition
- ☐ HIV
- ☐ Active cancer
- ☐ Solid organ transplant
- ☐ Hemopoietic stem cell transplant
- ☐ Other, specify _____

Symptoms from two days before to within 2 weeks after the positive test

☐ Symptomatic (check all that apply) ☐ Asymptomatic ☐ Unknown

☐ Fever >100.4F (38C) ☐ Chills ☐ Rigor ☐ Myalgia ☐ Headache ☐ Sore throat
☐ Nausea or vomiting ☐ Diarrhea ☐ Fatigue ☐ Congestion or runny nose ☐ Cough
☐ Shortness of breath ☐ Difficulty breathing ☐ New olfactory and taste disorders

Presented for outpatient medical care (telemedicine, clinic, urgent care, ER): ☐ Yes ☐ No ☐ Unknown
Hospitalized for >1 night within 2 weeks after positive test: ☐ Yes ☐ No ☐ Unknown
Admitted to an intensive care unit: ☐ Yes ☐ No ☐ Unknown
Required invasive medical ventilation (excludes BiPAP, CPAP): ☐ Yes ☐ No ☐ Unknown

Did patient die? ☐ No ☐ Yes, **date of death** _____

Person Completing Report _____ **Affiliation/Facility Name** _____ **Phone** _____ **Email** _____