Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

ADMINISTRATIVE ORDER
No. 2020 - 0013

APR 0 9 2020

SUBJECT: **Revised Administrative Order No. 2020-0012 "Guidelines for the Inclusion of the Coronavirus Disease 2019 (COVID-19) in the List of Notifiable Diseases for Mandatory Reporting to the Department of Health" dated March 17, 2020**

I. RATIONALE

Due to the recent developments related to the Coronavirus Disease 2019 (COVID-19) health event, the case definitions and surveillance system for notification of COVID-19 should be revisited and updated regularly. The availability of additional epidemiological information on COVID-19 further directs the Department of Health on how we detect, confirm, and report cases in the country.

Since January 28, 2020, the Philippines have used decision tools to classify individuals as either Patients Under Investigation or Persons Under Monitoring. However, the evidence of local and community transmission of COVID-19 necessitated a review on the assessment and classification of individuals with the aim of early detection and laboratory confirmation, especially among high risk and vulnerable populations, to guide appropriate clinical management and referral. The country is also challenged on how to cope with the sudden surge of confirmed cases and must identify measures to ensure that the health system will capably respond to this emergency to reduce the number of serious and critically ill cases and fatalities while maintaining essential and other routine health services. This amendment also adapted certain provisions of the World Health Organization (WHO) interim guideline on global surveillance for COVID-19 released on March 20, 2020, which provides for the use of case definitions for surveillance (suspect, probable, and confirmed), recommendations for laboratory testing, and reporting of surveillance data.

Thus, the following provisions of Administrative Order No. 2020-0012 on the guidelines for the inclusion of the COVID-19 in the list of notifiable disease for mandatory reporting to the DOH is hereby amended, as follows:

1. Shift from classifying individuals as Patients Under Investigation (PUI) and Persons Under Monitoring (PUM) to using case definitions to classify cases into Suspect, Probable, and Confirmed COVID-19 cases.
2. Establish a standard for and system of case detection, investigation, laboratory confirmation, and notification

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II. OBJECTIVES

This Order seeks to provide the guidelines on how COVID-19 cases shall be detected in health facilities through: (a) reporting health facilities that will serve as sentinel sites, such as the reporting sites for Severe Acute Respiratory Infection (SARI) and Influenza-like Illness (ILI) surveillance systems and city health offices of highly urbanized cities, (b) non-sentinel sites, such as hospitals and health centers, and (c) national and subnational reference laboratories and other laboratory facilities. Also, it describes the use of the Event-Based Surveillance and Response (ESR) system to capture clustering or sudden increase of cases of ILI and SARI and deaths of unknown etiology in the community.

Specifically, these guidelines on COVID-19 case detection, laboratory confirmation, and notification shall:

1. Establish a standardized mechanism of case detection, laboratory confirmation, and notification among existing surveillance systems and among the Epidemiology Bureau (EB), regional and local epidemiology and surveillance units, sentinel, non-sentinel, and laboratory facilities in terms of case definition, epidemiologic investigation, laboratory sample collection and confirmation, notification, and feedback;
2. Establish epidemiological, clinical, and virologic characteristics of COVID-19;
3. Characterize areas as to status of local and community transmission; and
4. Generate data as the basis for informed policy and intervention measures to contain and mitigate the spread of COVID-19.

III. SCOPE AND COVERAGE

This Order shall cover all individuals, health facilities and offices (public and private), national and sub-national laboratories, other laboratory facilities, civil society organizations, professional/medical/paramedical societies, and international organizations/donors/partners involved in disease surveillance; mandatory reporting of notifiable diseases; health events of public health concern; and the implementation of these guidelines.

IV. DEFINITION OF TERMS

As used in this Administrative Order, the following terms shall mean:

A. Case – a person with a particular problem requiring or receiving medical or welfare attention. A case is often used to label individuals further as suspect, probable, or confirmed.

B. Case definition – a set of standard criteria for classifying whether a person has a particular disease, syndrome, or other health condition.

C. Case investigation – profiling of suspect, probable, and confirmed COVID-19 case, which include but is not limited to review of medical, surveillance, and laboratory records, case interview, and review of other records and documentation.

D. Close contact – is a person without proper personal protective equipment (PPE) who is providing direct care for a confirmed COVID-19 case and a person who had direct physical contact, or lived, worked, transacted, or travelled in close proximity (less than 1 meter) for more than 15 minutes with a confirmed COVID-19 case.

E. **Cluster** – is an unusual aggregation, real or perceived, of health events that are grouped together as to time and space and that is reported to a public health department.

F. **Influenza-like Illness (ILI)** – is a condition with sudden onset *(within 3 days of presentation and fever should be measured at the time of presentation)* of fever of ≥38°C and cough or sore throat in the absence of other diagnoses

G. **Public Health Authority** – the Department of Health, specifically, the Epidemiology Bureau, Disease Prevention and Control Bureau, Bureau of Quarantine, Food and Drug Administration, Regional Offices of DOH, Regional Epidemiology and Surveillance Units (RESU); local health offices (provincial, city, or municipality); or any person directly authorized to act on behalf of the Department of Health or the local health office.

H. **Severe Acute Respiratory Infection (SARI)** - is an acute respiratory illness with onset during the previous 7 days requiring overnight hospitalization. A SARI case should meet the ILI case definition AND any one of the following: (a) shortness of breath or difficulty of breathing, (b) severe pneumonia of unknown etiology, acute respiratory distress, or severe respiratory disease possibly due to novel respiratory pathogens (such as COVID-19).

V. GENERAL GUIDELINES

A. Coronavirus Disease 2019 (COVID-19) is a notifiable disease as per Administrative Order No. 2020-0012 dated March 17, 2020 and its reporting shall be mandatory.

B. The COVID-19 Surveillance shall utilize existing surveillance systems, such as the ILI and SARI surveillance systems and the Event-based Surveillance and Response System, for detection of COVID-19 cases.

C. All DOH hospitals and level three (3) private hospitals and medical centers and health offices of highly urbanized cities shall serve as the sentinel reporting sites for COVID-19 surveillance. Cases seen at non-sentinel hospitals and health centers and results of COVID-19 tests done at laboratory facilities shall also be mandatorily reported.

D. Case definitions for COVID-19 shall be used to ensure proper classification and appropriate management of cases.

E. Laboratory confirmation for COVID-19 remains essential in determining the true burden of this disease.

VI. SPECIFIC GUIDELINES

A. COVID-19 Surveillance System

1. The Epidemiology Bureau (EB) of the Department of Health shall lead in establishing and implementing the **COVID-19 Surveillance System** and cases will be detected through the following:

1.1. Expanded SARI Sentinel Surveillance System

The COVID-19 surveillance shall utilize existing SARI sentinel sites as well as the additional sentinel sites to be identified, including DOH and Level III hospitals and medical centers, as sites for sentinel-based notification of COVID-19 cases.

1.2. Enhanced ILI Sentinel Surveillance System

The COVID-19 surveillance shall utilize existing ILI sentinel sites as well as the additional sentinels to be identified, prioritizing inclusion of highly urbanized cities, as sites for sentinel-based notification of COVID-19 cases as well as reporting of aggregate ILI data.

1.3. Notification from Health Facilities and Laboratory Facilities

Health facilities, such as hospitals and health centers, shall record and report consultations and/or admissions who fit any of the COVID-19 case definitions. Also, laboratory facilities conducting testing for COVID-19 shall notify DOH, through the set notification system, of individuals who underwent testing for COVID-19 and their results.

1.4. Event-based Surveillance and Response

Clustering or sudden increase of ILI and SARI cases and deaths of unknown etiology shall be reported through the ESR system

2. **Case definitions** for notification shall be based on the current information available and shall be updated accordingly. This amendment shall define the transition from reporting individuals as Patients Under Investigation (PUI) and Persons Under Monitoring (PUM) ***(See Annex A)*** to Suspect, Probable, and Confirmed COVID-19 cases.

2.1. 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:
   ii. 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
   iii. 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

2.2. 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 confirmatory testing

2.3. 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.

3. Case Detection

3.1. SARI and ILI Sites and Other Health Facilities, Providers, and Institutions

The identified SARI and ILI surveillance sites shall detect COVID-19 cases among its consultations and admission using the set case definitions. Other health facilities and providers and other institutions, including hospitals, health centers, and clinics, shall also detect COVID-19 cases among its consultations and admission using the set case definitions.

The ILI sites and identified health offices in highly urbanized cities shall submit weekly aggregate data on total consultations of ILI disaggregated as to age, sex, date of onset of illness, and place of residence.

Case investigation of detected and/or reported suspect, probable, and confirmed COVID-19 cases shall be undertaken by designated or trained disease surveillance officers (DSO) at these facilities using a standard case investigation form ***(See Annex B)***. In the absence of a designated or trained DSO at the facility, personnel of the Infection Control Unit or a similar office, shall conduct the case investigation. In the absence of any personnel capable of conducting case investigations at these facilities, the higher level office shall supervise and provide technical guidance or take the lead. Provincial Epidemiology and Surveillance Units (PESU) shall supervise or take lead for health facilities, providers, and offices and institutions at the municipal and component city and the Regional Epidemiology and Surveillance Unit (RESU) for those in highly urbanized cities and PESU, if latter has limited capability to supervise or lead. The investigation shall include but is not limited to the following: review of medical records, case interview, and laboratory sample collection and its results.

Officials and staff of health facilities and providers and concerned institutions shall comply with the request for access to patient and laboratory records for the purpose of this case investigation.

The health facility where any of these suspect, probable, or confirmed COVID-19 cases are admitted shall conduct daily monitoring of cases as to their status

and consolidate hospital census related to COVID-19 using the set template ***(See Annex C)***. Identified deaths among these cases shall be profiled using the set format.

Confirmed COVID-19 cases assessed as asymptomatic or clinically recovered by their attending physician shall be tested and will be discharged after at least one negative result. Confirmed COVID-19 cases who have clinically recovered or are well with negative results on repeat testing shall be reported as RECOVERED. If said discharged cases develop new signs or symptoms or progression from mild to more serious signs and symptoms, he/she shall be re-admitted once more to isolation and re-testing done. This guideline shall be reviewed and revised accordingly.

3.2. Laboratory Facilities

ALL Laboratory facilities conducting testing for COVID-19 shall notify DOH daily of official results of individuals tested for COVID-19, regardless of the test result.

Laboratory confirmation for COVID-19 shall be performed by the Research Institute for Tropical Medicine (RITM), five (5) sub-national laboratories (SNL) following the Regional Zoning of Services of National Reference and Subnational Laboratories for SARI ***(See Annex D)***, and officially accredited laboratory facilities. Note that this zoning may be updated in subsequent issuances. The RITM and DOH will work to improve the capabilities of these laboratories.

Current available laboratory confirmation for COVID-19 is done through real time/conventional Reverse Transcriptase-Polymerase Chain Reaction (RT-PCR). This may be updated as additional, officially recognized laboratory confirmatory testing becomes available.

Laboratory testing facilities should fulfill the following for it to be officially accredited by RITM as a COVID-19 laboratory confirmation testing facility:

a. Submit a self-assessment to RITM
b. Undergo and pass Proficiency Testing
c. Have five positive samples pass RITM external quality assessment.

If the laboratory does not pass all three criteria, result of any test conducted at their facility shall not be recognized as a laboratory confirmation test but shall still be submitted to DOH.

3.3. Event-based Surveillance and Response System

Local health authorities through the local epidemiology and surveillance units (LESU) shall report all health events, to include rumors of clustering or sudden increase of cases of ILI and SARI and deaths of unknown etiology.

4. **Epidemiologic Investigation**

Confirmed COVID-19 cases shall be investigated using the WHO Revised Case Report Form for COVID-19 ***(See Annex E)***. This epidemiologic investigation shall provide a more comprehensive profile of the confirmed COVID-19 case, including exposure and travel histories prior to onset of illness and until the case's isolation as well as clinical information. The concerned LESU, as determined by RESU, shall lead this epidemiologic investigation and corresponding response activities. However, in the absence of any personnel capable of conducting epidemiologic investigations and/or response activities at local health offices, the higher level office can take the lead. The PESU shall take lead for health offices at the municipal and component city and the RESU for health offices of highly urbanized cities and PESU, if latter has limited capability to lead.

Also, where clustering or sudden increase of SARI and ILI cases and deaths of unknown etiology or any reported confirmed COVID-19 case had been identified, the local health authorities through the LESU shall coordinate with their respective RESU for a joint or a supervised investigation of cases or health event. This investigation should be able to provide better understanding of the epidemiology of the event and to ensure proper case and health event management.

Officials and staff of health facilities and other institutions shall comply with the provision of R.A. 11332, otherwise known as Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act, regarding epidemiologic investigation of notifiable diseases, including COVID-19. Representatives of EB and its regional and local counterparts shall be given full access to patient and laboratory records for the purpose of this epidemiologic investigation.

The investigating team shall be equipped with appropriate and complete personal protective equipment (PPE) during investigation.

B. Laboratory Confirmation

Current guidelines recommend the collection of nasopharyngeal and oropharyngeal swabs (NPS/OPS) for laboratory confirmatory testing. For a SARI case who is a suspect COVID-19 case, lower tract specimens like sputum, tracheal aspirate, and/or bronchi alveolar lavage, may also be collected aside from NPS/OPS. These guidelines on sample collection shall be reviewed and updated.

Current guidelines also list cases we shall prioritize for testing. However, once additional epidemiological information and projections are available, said guidelines shall be reviewed and revised, as needed. The following shall be prioritized for testing:

a. Suspect cases who are assessed as serious or critical
b. Suspect cases fitting any one of the conditions:
    i. Aged 60 years and above
    ii. With a comorbidity
    iii. Assessed as a high-risk pregnancy
    iv. Health workers

c. Health workers assessed as with high risk of exposure, even in the absence of any sign or symptom
d. Clusters of ILI or SARI

The collection, storage, and transport of specimens from reporting health facility or office to the laboratory shall be facilitated by the designated disease surveillance officer. Laboratory collection shall be done by a trained health staff in the health facility where case was detected and submitted to designated and official laboratory testing facilities. Staff who conduct laboratory sample collection shall be equipped with appropriate and complete personal protective equipment (PPE) during collection of specimens. All cases with laboratory specimens collected shall be coordinated with the RESU.

All collected specimens shall be transported within 48 to 72 hours upon collection and stored at 2 °C to 8 °C. If specimens will not be transported within 72 hours, store the specimen in the freezer.

A laboratory quality assurance of DOH SNL shall be implemented by RITM through its Molecular Biology Laboratory (MBL). The MBL should ensure that a Biosafety, Biosecurity, and Laboratory Quality Assurance team shall be deployed to all DOH SNL.

Other hospitals with existing capacity for laboratory confirmatory testing for COVID-19 shall provide RITM with aliquots of their samples for re-testing as part of Laboratory Quality Assurance.

C. Recording and Notification System

Health authorities from the government and private sectors, including health facilities, laboratory testing facilities, offices, institutions, and individuals, are mandated to report suspect, probable, and confirmed cases of COVID-19 and results of COVID-19 testing done within 24 hours of identification or completion of testing.

1. Designation of a Dedicated COVID-19 Coordinator

All public and private health facilities and providers that admit and give consultations to suspect, probable, and confirmed COVID-19 cases and/or laboratory facilities that conduct testing for COVID-19 must identify and designate a COVID-19 coordinator and his/her alternate. The COVID-19 Coordinator shall ideally be the head of or point person for the concerned epidemiology and surveillance unit, ICC, or laboratory facility, whichever is applicable. The COVID-19 coordinator shall:

a. Serve as the main liaison between the DOH and the health facility, health provider, or laboratory facility for all communication on COVID-19 concerns including but not limited to data requests, validation, and follow-up;
b. Continuously coordinate with the EB COVID-19 surveillance team to facilitate immediate and timely accommodation of all surveillance, laboratory data submission, and contact tracing activities such as but not

limited to: reviewing patient records, interviewing patients, relatives, and other health care providers and other concerned personnel of the facility, and immediate submission of laboratory results;

c. Promptly and correctly update the DOH COVID-19 Information System.

All public and private health facilities, health providers, and laboratory facilities shall provide the DOH with the following details of their assigned COVID-19 coordinator and alternate:

a. Name
b. Position
c. Cell phone number
d. E-mail Address

Details shall be submitted to the EB COVID-19 surveillance team covidcontacttracing.eb@gmail.com with the subject header "[COVID-19] Coordinator for <name of facility>".

2. Case Notification and Monitoring

2.1. Case Notification and Submission of COVID-19 Laboratory Test Results

Information on suspect, probable, and confirmed COVID-19 cases shall be recorded using the COVID-19 Case Investigation Form or CIF ***(See Annex B)*** and reported within 24 hours using a set notification system ***(See Annex F)***. The health facility or provider or concerned institution, shall submit within 24 hours of detection the accomplished CIF to RESU, who shall in turn submit this to EB.

For reported clustering or sudden increase of ILI and SARI cases or deaths of unknown etiology, these shall be reported through the ESR system also within 24 hours. The health facility or provider or concerned institution shall inform the RESU of identified suspect cases and health events. The RESU shall in turn notify EB immediately. However, upon detection of a probable or confirmed COVID-19 case, the reporting unit shall immediately notify the EB and RESU, simultaneously.

Laboratory results from the national reference laboratory, subnational referral laboratory, and laboratory testing facilities shall be submitted to DOH within 24 hours of completion of test using the same notification system. However, if the result was equivocal or positive, this report should be submitted immediately. Laboratories should diligently accomplish the lab reporting form in **Annex G.**

A transmittal of laboratory results shall be released by RITM following the protocol for releasing laboratory results. The transmittal shall be shared to designated officials after vetting of their Head of Office. This transmittal shall be considered official. Signed individual laboratory results shall be shared as soon as available. These transmittal and individual laboratory results shall be released by RITM to the Office of the Secretary of Health and duly identified members of DOH Executive Committee, the Infection Control Committee (ICC) head or point person of requesting

hospitals, EB, and the concerned RESU. The RESU will inform their regional director (RD) and assistant regional director (ARD), who in turn inform the concerned LGU.

For subnational reference laboratories and other testing facilities, laboratory results shall be immediately sent by their heads of offices to the DOH Executive Committee, EB, RITM, RESU, and the Infection Control Committee (ICC) head or point person of requesting hospitals. An official transmittal shall be sent immediately but signed individual laboratory results should follow. The RESU in turn informs their respective RD and ARD, who in turn inform the concerned LGU.

2.2. Case Monitoring

A template shall be submitted daily by **5 PM** which will include status of admitted suspect, probable, or confirmed COVID-19 cases ***(See Annex B)***. If any of these became a fatality, this should be immediately reported to RESU using the set format, who shall in turn immediately notify EB. The following information shall be updated:

a. Medical Status (of condition, as of time of update), including current signs and symptoms
b. Laboratory Status
c. For fatalities:
    i. Date and Time of Death
    ii. Cause of Death
    iii. Comorbidities
d. Disposition
e. Remarks: any other relevant notes from the patient chart; indicate especially if the patient is using a ventilator.

The COVID-19 coordinator shall provide detailed information on the death listed above, as well as other pertinent information from patient records.

For health facilities and providers and laboratory facilities with capability to set-up and use the COVID-19 Information System, the EB COVID-19 surveillance team shall assist the assigned COVID-19 coordinators in setting up their accounts to access the COVID-19 Information System website. This shall serve as the main data repository of COVID-19 data from all health facilities.

Confirmed COVID-19 cases who are currently isolated at home or in a non-health facility, the LESU shall be responsible in monitoring the clinical status of the patients and collect sample for repeat testing at the end of the 14-day isolation period.

2.3. Utilizing the COVID-19 Information System

The COVID-19 coordinator shall accurately and diligently input all required information on all suspect, probable, and confirmed COVID-19 cases that are

admitted or have consulted at the facility using this system. In turn, laboratory facilities conducting COVID-19 testing shall input case information and upload the official transmittal and laboratory result.

The COVID-19 coordinator ***must*** update the COVID-19 Information System website sheets **daily** without need for prompting by **5:00 PM.** The COVID-19 coordinator must pay special attention to *ensure that the following variables are updated*:

a. Medical Status (of condition, as of time of update), including current signs and symptoms
b. Laboratory Status
c. For fatalities:
    i. Date and Time of Death
    ii. Cause of Death
    iii. Comorbidities
d. Disposition
e. Remarks: any other relevant notes from the patient chart; indicate especially if the patient is using a ventilator.

The RESU will review the data after submission. They may call the COVID-19 coordinator to follow-up for updates or clarify certain data entries. Likewise, the COVID-19 coordinator may contact the RESU for any questions or clarification with regards to the reporting forms. The EB Data Managers shall coordinate with the RESU for data requiring further verification.

Designated disease surveillance staff in these sentinel sites and disease reporting units shall implement and exercise zero reporting and notify the RESU, who shall in turn notify EB.

VII. ROLES AND RESPONSIBILITIES

A. The Epidemiology Bureau shall:

1. Lead in the establishment and implementation of the COVID-19 Surveillance System.
2. Draft and issue required policies and guidance in relation to this surveillance system.
3. Conduct training, orientation, and/or technical assistance to ensure that disease reporting units and concerned stakeholders will know how to implement the system.
4. Shall be the process owner of the COVID-19 Information System and as such shall:
    a. Act as the Database Managers for surveillance data
    b. Liaise with the COVID-19 coordinators for the timely turnover of complete data and information
    c. Review and approve updated attribute data which may be submitted by the users
5. Draft and disseminate COVID-19 surveillance report.
6. Assess and coordinate with respective RESUs all reported clustering, sudden increase, and local transmission of COVID-19 within 24 hours upon receipt of detection of clustering, sudden increase, or local transmission.

7. When necessary, provide support through technical staff and logistic assistance during epidemiologic investigation and response.
8. Oversee the design of appropriate reporting software for the inclusion of COVID-19 into the SARI/ILI, existing hospital sentinel surveillance and/or information system, and community-based disease surveillance system.
9. Facilitate dissemination of related information, policies, and recommendations from DOH Central Office and the World Health Organization (WHO) to the concerned agencies and institutions.
10. Allocate funds for the operation of the COVID-19 surveillance system.
11. Monitor the implementation of the system.
12. Notify the WHO as part of International Health Regulations commitment

B. The RESU shall assume the roles and responsibilities of EB at the regional level:

1. Lead in the establishment and implementation of the COVID-19 Surveillance System at the regional level.
2. Identify strategies and activities to operationalize the surveillance system at their level and at local health offices and disease reporting units.
3. Conduct data verification of submitted CIF and/or records and reports encoded in the COVID-19 Information System.
4. Conduct training, orientation, and/or technical assistance to ensure that disease reporting units and concerned stakeholders will know how to implement the system.
5. Prepare and disseminate COVID-19 surveillance report.
6. Disseminate related information, policies, and recommendations from DOH Central Office and the World Health Organization (WHO) to the health facilities, disease reporting units, and concerned agencies and institutions at their level.
7. Allocate funds for the COVID-19 surveillance system.
8. Monitor the implementation of the system.

C. The Bureau of Quarantine (BOQ) shall:

1. Conduct surveillance in ports and airports of entry and sub-ports as well as the airports and ports of origin of international flights and vessels.
2. Collect completed health declaration cards and enter into the database management system.
3. Perform entry screening and preliminary investigation of all suspected cases identified in all ports of entry and exit.
4. Provide the passenger manifest and other relevant information to EB and/or RESU for case investigation and contact tracing.
5. Allocate funds for the COVID-19 surveillance system.
6. Monitor public health threats in other countries.

D. The National Reference Laboratory (Research Institute for Tropical Medicine):

1. Allocate funds for laboratory testing for COVID-19 and other SARI pathogens.
2. Allocate funds to support quality assurance activities of sub-national and other laboratories
3. Provide confirmatory services to COVID-19 cases.

4. Provide funds and technical support for specimen collection, transport, and storage from the sites to the laboratory.
5. Provide technical support, training, and quality assurance to the subnational laboratories and officially accredited laboratory testing facilities.
6. Assess testing facilities for accreditation as an official laboratory confirmatory testing facility.
7. Provide laboratory results to designated DOH officials, EB, RESU, and health facilities and disease reporting units.

E. Subnational Reference Laboratories and DOH-Certified Laboratory Testing Facilities shall:

1. Provide confirmatory services to suspect COVID-19 cases.
2. Provide laboratory results to DOH and its identified officials and offices and requesting health facilities.
3. Allocate funds for the COVID-19 surveillance system.

F. Field Implementation and Coordination Team, Centers for Health Development, Health Facility and Services Regulatory Bureau, and PhilHealth

1. Assist EB and RESU in ensuring compliance of health facilities, health providers, and laboratory facilities, both government and private, to guidelines for recording, investigation, and notification of suspect, probable, and confirmed COVID-19 cases
2. Assist the DOH Database Managers in following up and ensuring the timely submissions of government and private health facilities, health providers, and laboratory facilities

G. Knowledge Management and Information Technology Service (KMITS) shall:

1. Provide assistance in using the data entry platform
2. Resolve issues, concerns, and problems on the development, utilization, and implementation of the system;
3. Implement monitoring and evaluation mechanisms to improve data quality and use, including documenting and reporting of users' feedback and recommended improvements in the system

H. Provincial and City/Municipal Health Offices of Highly Urbanized Areas shall:

1. Orient and or re-orient hospital staff on mandatory disease reporting requirements
2. Support the operation of the epidemiology and surveillance unit through the following:
   a. Identify and designate health staff to be trained and assigned as the COVID-19 Coordinator
   b. Assign a staff for data encoding and a dedicated table top computer and other IT requirements such as internet connection for reporting are available.
   c. Allocate budgetary support through the incorporated in the annual work and financial plan of the provincial/city/municipal health office the operation of the ESU for effective disease surveillance system

I. Local (Provincial, City, and Municipal) Epidemiology and Surveillance Units shall:

1. Lead in the investigation, validation, contact tracing, monitoring of reported cases of COVID-19, and other response activities. This includes investigation of reported clustering cases.
2. Conduct training, orientation, and/or technical assistance to public health associates (PHAs) and barangay health emergency response teams (BHERTs) on case identification, close contact monitoring, and reporting of persons under quarantine, underscoring the importance of mandatory disease reporting requirements for COVID-19 surveillance.
3. Operationalize the surveillance system at their level
4. Allocate funds for the operation of the COVID-19 surveillance and response

J. Role of Health Facilities and Disease Reporting Units shall:

1. Orient or re-orient hospital/health facility staff regarding mandatory disease reporting requirements for COVID-19 surveillance.
2. Designate disease surveillance coordinators who will be responsible for preliminary investigation of suspect cases seen at the hospital.
3. Designate an COVID-19 coordinators, ideally the Hospital Epidemiology and Surveillance Unit or Infection Prevention and Control Head or Point Persons, who shall be responsible in: (a) ensuring completion and submission of CIF and/or encoding using the COVID-19 Information System, (b) ensuring laboratory sample collection and transport, (c) receive laboratory results, and (d) disclose laboratory results to attending physicians and/or case.
4. Assign a dedicated encoder and provide IT requirements for recording and notification.
5. Coordinate with EB and RESU, especially during case investigation and close contact tracing.
6. Provide access to medical records, facilitate case interviews, and other case investigation and contact tracing activities.
7. Provide daily updates to RESU as to case status of admitted suspect, probable, or confirmed cases using prescribed template.
8. Allocate funds for the COVID-19 surveillance system.

VIII. REPEALING CLAUSE

Administrative Order No. 2020-0012 dated March 17, 2020 entitled "Guidelines for the Inclusion of the Coronavirus Disease 2019 (COVID-19) in the List of Notifiable Diseases for Mandatory Reporting to the Department of Health" and all other issuances inconsistent with this Order are hereby repealed, rescinded, amended or modified accordingly.

IX. EFFECTIVITY

This Order shall take effect immediately.

FRANCISCO T. DUQUE, III, MD, MSc
Secretary of Health

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APR 13 2020
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RECORDS SECTION

Annex A. Transition of the Old versus New Classification for COVID-19

OLD CLASSIFICATION	NEW CLASSIFICATION
Neither a Person Under Monitoring (PUM) or Patient Under Investigation	Not a COVID-19 Case
PUM	Not included in the new classification*
PUI (mild, severe, or critical) who was not tested or awaiting test results	Suspect
PUI (mild, severe, or critical) with inconclusive test results	Probable
COVID Positive	Confirmed

*Because of evidence of local or community transmission in the country, its residents are assumed to have been exposed to the infection

Annex B. COVID-19 Case Investigation Form

Case Investigation Form
Coronavirus Disease (COVID-19)

COVID-19 Case Definitions:

Annex C. Status Update for COVID-19 Admissions

Name of Reporting Hospital: _____
Address: _____

Total Number of Admissions: _____

- No. Suspect Cases: _____
- No. Probable Cases: _____
- No. Confirmed Cases: _____

Name of Patient	Medical Status Update and Current Significant Signs and Symptoms (Asymptomatic, Mild, Severe, Critical, Death)	Laboratory Status (Positive, Negative, Pending)	If DEATH, fill in the following information			Disposition (Discharged, DAMA, HAMA, Absconded, Transferred; if transferred, indicate which facility)	Remarks (Intubated, On ventilator, etc.)
			Date and Time of Death	Cause of Death	List of Comorbidities		

Annex D. Regional Zoning of Services to National Reference and Sub-national Laboratories for SARI

Referral Facility	Type	Referring Region
Baguio General Hospital	Subnational Laboratory	Region I – Ilocos Region Region II – Cagayan Valley Cordillera Autonomous Region
Lung Center of the Philippines	Subnational Laboratory	Region III – Central Luzon National Capital Region – First District National Capital Region – Second District
San Lazaro Hospital	Subnational Laboratory	National Capital Region – Third District Region IVA (CALABARZON)– Only Rizal Province Region IVB – MIMAROPA
Research Institute of Tropical Medicine	NRL	National Capital Region – Fourth District Region IVA (CALABARZON)– Except Rizal Province Region V – Bicol
Vicente Sotto Memorial Medical Center	Subnational Laboratory	Region VI – Western Visayas Region VII – Central Visayas Region VIII – Eastern Visayas CARAGA Region
Southern Philippines Medical Center	Subnational Laboratory	Region IX – Zamboanga Region X – Northern Mindanao Region XI – Davao Region XII – SOCCSKSARGEN Bangsamoro Autonomous Region for Muslim Mindanao

Annex E. WHO Case Report Form

World Health Organization

Revised case report form for Confirmed Novel Coronavirus COVID-19 (report to WHO within 48 hours of case identification)

Date of reporting to national health authority: [_][_]/[_][_]/[_][_][_][_]

Reporting country: _____

Why tested for COVID-19:

□ Contact of a case □ Ill Seeking Healthcare due to suspicion of COVID-19 □ Detected at point of entry □ Repatriation
□ Routine respiratory disease surveillance systems (e.g. influenza) □ Unknown
If none of the above, please explain: _____

Section 1: Patient information

Unique Case Identifier (used in country): _____

Age (years): [__][__][__] If < 1 year old, [__][__] in months or if < 1 month, [__][__] in days

Sex at birth: □ Male □ Female

Place where the case was diagnosed: Country: _____
Admin Level 1 (province): _____

Case usual place of residency: Country: _____

Section 2: Clinical Status

Date of first laboratory confirmation test: [_][_]/[_][_]/[_][_][_][_]

Any symptoms* or signs *at time of specimen collection that resulted in first laboratory confirmation*?
□ No (i.e., asymptomatic) □ Yes □ Unknown
If yes, date of onset of symptoms: [_][_]/[_][_]/[_][_][_][_]

Underlying conditions and comorbidity:
Any underlying conditions? □ No □ Yes □ Unknown

If yes, please check all that apply:

□ Pregnancy (trimester: _____)
□ Cardiovascular disease, including hypertension
□ Diabetes
□ Liver disease
□ Chronic neurological or neuromuscular disease
□ Other(s), please specify:
□ Post-partum (< 6 weeks)
□ Immunodeficiency, including HIV
□ Renal disease
□ Chronic lung disease
□ Malignancy

v

Health Status at time of reporting:

Admission to hospital: ○ No ○ Yes ○ Unknown
First date of admission to hospital: [ ][ ]/[ ][ ]/[ ][ ][ ][ ]

If yes
Did the case receive care in an intensive care unit (ICU)? ○ No ○ Yes ○ Unknown
Did the case receive ventilation? ○ No ○ Yes ○ Unknown
Did the case receive extracorporeal membrane oxygenation? ○ No ○ Yes ○ Unknown

In case in isolation with Infection Control Practice in place ○ No ○ Yes ○ Unknown
Date of isolation: [ ][ ]/[ ][ ]/[ ][ ][ ][ ]

Section 3: Exposure risk in the 14 days prior to symptom onset (refer to section 8 for definitions)

Is case a Health Care Worker (any job in a health care setting): ○ No ○ Yes ○ Unknown

If yes, Country: ..... City: ..... Name of facility: .....

Has the case **travelled** in the 14 days prior to symptom onset? ○ No ○ Yes ○ Unknown
If yes, please specify the places the patient travelled to and date of departure from the places.

	Country	City	Date of Departure from the place
1.	Country	City	Date .....
2.	Country	City	Date .....
3.	Country	City	Date .....

Has case **visited any health care facility** in the 14 days prior to symptom onset? ○ No ○ Yes ○ Unknown

Has case **had contact with a confirmed case** in the 14 days prior to symptom onset? ○ No ○ Yes ○ Unknown
If yes, please list unique case identifiers of all probable or confirmed cases:
If yes, please explain contact setting .....

	Contact ID	First Date of Contact	Last Date of Contact
1.	.....	Date	Date .....
2.	.....	Date	Date .....
3	.....	Date	Date .....
4	.....	Date	Date .....
5	.....	Date	Date .....

Most likely country of exposure: .....

World Health Organization

Section 4: Outcome : complete and re-sent the full form as soon as outcome of disease is known or after 30 days after initial report.

Date of re-submission of this report: [ ][ ]/[ ][ ]/[ ][ ][ ][ ]

If case was asymptomatic at time of specimen collection resulting in first laboratory confirmation, did the case develop any symptoms or signs *at any time* prior to discharge or death:

- ▫ No (i.e., case remains asymptomatic)
- ▫ Yes, asymptomatic case (as previously reported) developed symptoms and/or signs of illness

  If yes, date of onset of symptoms/signs of illness: [ ][ ]/[ ][ ]/[ ][ ][ ][ ]

- ▫ Unknown

Clinical Course:

Admission to hospital (may have been previously reported): ▫ No ▫ Yes ▫ Unknown

If admitted to hospital:

First date of admission to hospital: [ ][ ]/[ ][ ]/[ ][ ][ ][ ]

Did the case receive care in an intensive care unit (ICU)? ▫ No ▫ Yes ▫ Unknown
Did the case receive ventilation? ▫ No ▫ Yes ▫ Unknown
Did the case receive extracorporeal membrane oxygenation? ▫ No ▫ Yes ▫ Unknown

Health Outcome: ▫ Recovered/Healthy ▫ Not recovered ▫ Death ▫ Unknown: ▫ Other:

If other, please explain: _____

Date of Release from isolation/hospital or *Date of Death*: [ ][ ]/[ ][ ]/[ ][ ][ ][ ]

If released from hospital /isolation, date of last laboratory test:

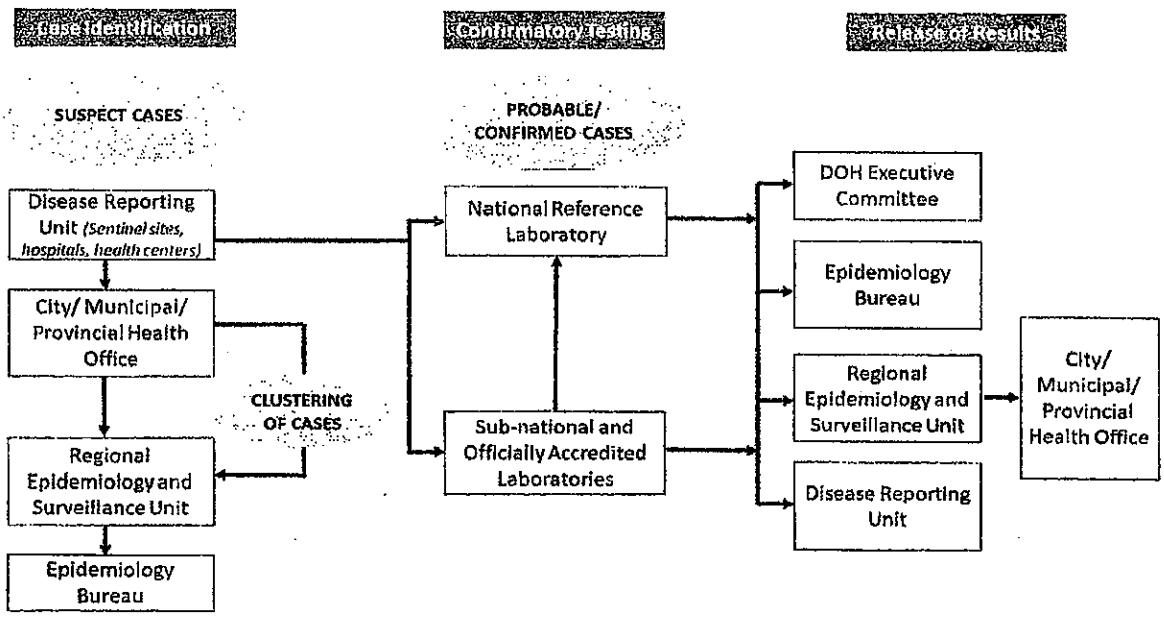
[ ][ ]/[ ][ ]/[ ][ ][ ][ ]

Results of last test: ▫ positive ▫ negative ▫ Unknown

Total number of contacts followed for this case: _____ ▫ Unknown

WHO reference number: WHO/2019-nCoV/SurveillanceCRF/2020.2

Annex F. COVID-19 Surveillance Notification System



Annex G. Laboratory Results Reporting Template

Name of Laboratory Facility: _____

Address: _____

Name (Last Name, First Name, Middle Name)	Age	Sex	Name Of Requesting Facility	Type Of Laboratory Facility : NRL, SNL, Or Non-NRL/SNL	Type Of Specimen (NPS, OPS, Serum, Etc.)	Date Specimen Collected (mm/dd/yyyy)	Date Specimen Received (mm/dd/yyyy)	Date Results Released (mm/dd/yyyy)	Test Results

Approving Official: Date Approved:

Name
Designation