



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

May 25, 2021

DEPARTMENT MEMORANDUM

No. 2021- 0285

FOR : **ALL UNDERSECRETARIES AND ASSISTANT SECRETARIES; DIRECTORS OF BUREAUS AND CENTERS FOR HEALTH DEVELOPMENT; MINISTER OF HEALTH - BANGSAMORO AUTONOMOUS REGION IN MUSLIM MINDANAO; EXECUTIVE DIRECTORS OF SPECIALTY HOSPITALS; CHIEFS OF MEDICAL CENTERS, HOSPITALS, SANITARIA AND INSTITUTES; PRESIDENT OF THE PHILIPPINE HEALTH INSURANCE CORPORATION; ALL DISEASE REPORTING UNITS; ALL LOCAL GOVERNMENT UNITS; ALL HOSPITAL FACILITIES; ALL LICENSED COVID-19 TESTING LABORATORIES; AND OTHERS CONCERNED**

SUBJECT : **Implementation of the Use of the COVID-19 Case Investigation Form Version 9**

Department Memorandum No. 2020-0512 entitled the "Revised Omnibus Interim Guidelines on Prevention, Detection, Isolation, Treatment, and Reintegration Strategies for COVID-19" and Department Memorandum No. 2020-0436 entitled the "Minimum Data Requirements of COVID-19 Related Information Systems" mandated the use of the COVID-19 Case Investigation Form (CIF) Version 7 for case investigation and testing.

Relative to this, the CIF Version 7 was revised through the Department Memorandum No. 2021-0143 entitled the "Implementation of the Use of the COVID-19 Case Investigation Form Version 8" to ensure interoperability and served as the minimum data fields for the COVID-19 CIF and COVID-19 information systems. The updates and revisions in this latest CIF version address the needs of the Epidemiology and Surveillance Units (ESUs), Disease Reporting Units (DRUs), such as health facilities, local government units (LGUs), and laboratories. The revisions are as follows:

1. The **addition** of the following **mandatory** information:
 - a. **Passport Number** under number **1.5 Special Population**, for Returning Overseas Filipino (ROF) and Foreign National (FN)
 - b. Separate **facility name and facility location for healthcare workers** under number **1.5 Special Population**
 - c. **Vaccination Information** under **Section 2.5**
 - i. Date of vaccination
 - ii. Name of Vaccine
 - iii. Dose (1st and 2nd)
 - iv. Vaccination center/facility
 - v. Region of health facility
 - vi. Adverse events (Y/N)
 - d. **Brand kit for antigen test** under number **2.7 Laboratory Information Type of Test**


2. Changing the following field from **non-mandatory to mandatory**:
 - a. **Type of Client**
 - b. **Testing Category or Subgroup**
3. The removal of Indigenous Person on 1.5 Special Population

Furthermore, the accompanying amended Case Investigation Form Version 9 will be utilized as the standard form for COVID-19 notifiable disease reporting. The CIF Version 9 comes in two file formats: a printable form (See **Annex A**) and an electronic version which can be accessed through <https://tinyurl.com/cifversion9>. The format of choice shall be decided upon by the DRUs based on their capacity and means for filling up the CIF.

All laboratories, LGUs, and other disease reporting units with an existing system for generation of electronic CIFs shall comply with the revisions stated in this amendment.

All other provisions of DM No. 2020-0512 dated November 26, 2020 and DM No. 2020-0436 dated October 1, 2020 shall remain in effect.

For strict and immediate compliance and dissemination to all concerned.


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



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

Part 1. Patient Information			
1.1. Patient Profile			
Last Name*	First Name (and Suffix)*	Middle Name*	
Birthdate (MM/DD/YYYY)*	Age*	Sex*	<input type="checkbox"/> Male <input type="checkbox"/> Female
Civil Status	Nationality*		
Occupation	Works in a closed setting? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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*	<input type="checkbox"/> Yes, name of health facility: _____ and location: _____		<input type="checkbox"/> No
Returning Overseas Filipino*	<input type="checkbox"/> Yes, country of origin: _____ and Passport number: _____ OFW: <input type="checkbox"/> OFW <input type="checkbox"/> Non-OFW		<input type="checkbox"/> No
Foreign National Traveler*	<input type="checkbox"/> Yes, country of origin: _____ and Passport number: _____		<input type="checkbox"/> No
Locally Stranded Individual / APOR / Local Traveler*	<input type="checkbox"/> Yes, City, Municipality, & Province of origin _____ <input type="checkbox"/> Locally Stranded Individual <input type="checkbox"/> Authorized Person Outside Residence / Local Traveler		<input type="checkbox"/> No
Lives in Closed Settings*	<input type="checkbox"/> Yes, institution type: _____ and name: _____ (e.g. prisons, residential facilities, retirement communities, care homes, camps, etc.)		<input type="checkbox"/> No

Part 2. Case Investigation Details					
2.1. Consultation Information					
Have previous COVID-19 related consultation?		<input type="checkbox"/> Yes, Date of First Consult (MM/DD/YYYY)* _____		<input type="checkbox"/> No	
Name of facility where first consult was done					
2.2. Disposition at Time of Report* (Provide name of hospital/isolation/quarantine facility)					
<input type="checkbox"/> Admitted in hospital _____		Date and Time admitted in hospital _____			
<input type="checkbox"/> Admitted in isolation/quarantine facility _____		Date and Time isolated/quarantined in facility _____			
<input type="checkbox"/> In home isolation/quarantine		Date and Time isolated/quarantined at home _____			
<input type="checkbox"/> Discharged to home		If discharged: Date of Discharge (MM/DD/YYYY)* _____		<input type="checkbox"/> Others: _____	
2.3. Health Status at Consult* (Refer to Appendix 3)		<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Critical			
2.4. Case Classification* (Refer to Appendix 1)		<input type="checkbox"/> Suspect <input type="checkbox"/> Probable <input type="checkbox"/> Confirmed <input type="checkbox"/> Non-COVID-19 Case			
2.5. Vaccination information*					
Date of vaccination*	Name of Vaccine*	Dose number (e.g. 1 st , 2 nd)*	Vaccination center/facility	Region of health facility	Adverse event/s?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

2.6. Clinical Information		
Date of Onset of Illness (MM/DD/YYYY)* _____		Comorbidities (Check all that apply if present)
Signs and Symptoms (Check all that apply)		
<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Fever _____ °C <input type="checkbox"/> Cough <input type="checkbox"/> General weakness <input type="checkbox"/> Fatigue <input type="checkbox"/> Headache <input type="checkbox"/> Myalgia <input type="checkbox"/> Sore throat <input type="checkbox"/> Coryza	<input type="checkbox"/> Dyspnea <input type="checkbox"/> Anorexia <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Altered Mental Status <input type="checkbox"/> Anosmia (loss of smell, w/o any identified cause) <input type="checkbox"/> Ageusia (loss of taste, w/o any identified cause) <input type="checkbox"/> Others, specify _____	<input type="checkbox"/> None <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Lung Disease <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Genito-urinary <input type="checkbox"/> Neurological Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Others _____
Pregnant? <input type="checkbox"/> Yes, LMP (MM/DD/YYYY) _____ <input type="checkbox"/> No		High-risk pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was diagnosed to have Severe Acute Respiratory Illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Chest imaging findings suggestive of COVID-19		
Date done	Chest imaging done	Results
<input type="checkbox"/> Chest radiography <input type="checkbox"/> Chest CT <input type="checkbox"/> Lung ultrasound <input type="checkbox"/> None	<input type="checkbox"/> Normal <input type="checkbox"/> Pending	<input type="checkbox"/> Chest radiography: Hazy opacities, often rounded in morphology, with peripheral and lower lung dist. <input type="checkbox"/> Chest CT: Multiple bilateral ground glass opacities, often rounded in morphology, w/ peripheral & lower lung dist. <input type="checkbox"/> Lung ultrasound: Thickened pleural lines, B lines, consolidative patterns with or without air bronchograms <input type="checkbox"/> Other findings, specify _____

2.7. Laboratory Information				
Have tested positive using RT-PCR before? *	<input type="checkbox"/> Yes, date of specimen Collection (MM/DD/YYYY)* _____	<input type="checkbox"/> No		
	Laboratory* _____	No. of previous RT-PCR swabs done _____		
Date collected*	Date released	Laboratory*	Type of test*	Results*
			<input type="checkbox"/> RT-PCR (OPS) <input type="checkbox"/> Antigen; reason _____ <input type="checkbox"/> RT-PCR (NPS) <input type="checkbox"/> brand of kit _____ <input type="checkbox"/> RT-PCR (OPS and NPS) <input type="checkbox"/> Antibody Test <input type="checkbox"/> Others: _____	<input type="checkbox"/> Pending <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Equivocal <input type="checkbox"/> Others: _____
			<input type="checkbox"/> RT-PCR (OPS) <input type="checkbox"/> Antigen; reason _____ <input type="checkbox"/> RT-PCR (NPS) <input type="checkbox"/> brand of kit _____ <input type="checkbox"/> RT-PCR (OPS and NPS) <input type="checkbox"/> Antibody Test <input type="checkbox"/> Others: _____	<input type="checkbox"/> Pending <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Equivocal <input type="checkbox"/> Others: _____

2.8. Outcome/Condition at Time of Report*		
<input type="checkbox"/> Active (currently admitted/isolation/quarantine) <input type="checkbox"/> Recovered, date of recovery (MM/DD/YYYY)* _____ <input type="checkbox"/> 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? *	<input type="checkbox"/> Yes, date of last contact (MM/DD/YYYY)* _____	<input type="checkbox"/> No	<input type="checkbox"/> 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? *	<input type="checkbox"/> Yes, International	<input type="checkbox"/> Yes, Local	<input type="checkbox"/> No Unknown exposure		
If International Travel, country of origin _____	Inclusive travel dates: _____	From: _____	To: _____		
	With ongoing COVID-19 community transmission? <input type="checkbox"/> Yes <input type="checkbox"/> 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: To:	With ongoing COVID-19 Community Transmission? Yes No	
<input type="checkbox"/> Health Facility				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Closed Settings				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> School				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Workplace				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Market				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Social Gathering				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Others				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> 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)
- If symptomatic, provide names and contact numbers of persons who were with the patient two days prior to onset of illness until this date - 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		Name (Use the back page if needed)		Contact Number	

Appendix 1. COVID-19 Case Definitions

SUSPECT	PROBABLE
<p>A) A person who meets the clinical AND epidemiological criteria</p> <ul style="list-style-type: none"> - Clinical criteria: <ol style="list-style-type: none"> 1) Acute onset of fever AND cough OR 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 - Epidemiological criteria <ol style="list-style-type: none"> 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 2) Residing in or travel to an area with community transmission anytime w/in the 14 days prior to symptoms onset; OR 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 <p>B) A patient with severe acute respiratory illness (SARI: acute respiratory infection with history of fever or measured fever of $\geq 38^{\circ}\text{C}$; cough with onset w/in the last 10 days; and who requires hospitalization)</p>	<p>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</p> <p>B) A suspect case (on the left) with chest imaging showing findings suggestive of COVID-19 disease. Typical chest imaging findings include (Manna, 2020):</p> <ul style="list-style-type: none"> - Chest radiography: hazy opacities, often rounded in morphology, with peripheral and lower lung distribution - Chest CT: multiple bilateral ground glass opacities, often rounded in morphology, with peripheral and lower lung distribution - Lung ultrasound: thickened pleural lines, B lines (multifocal, discrete, or confluent), consolidative patterns with or without air bronchograms <p>C) A person with recent onset of anosmia (loss of smell), ageusia (loss of taste) in the absence of any other identified cause</p> <p>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</p>
	CONFIRMED
	<p>A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.</p>

Appendix 2. Testing Category / Subgroup

A	Individuals with severe/critical symptoms and relevant history of travel/contact	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.
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	H	Frontliners in Tourist Zones:
C	Individuals with mild symptoms, and relevant history of travel and/or contact	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.
D	Individuals with no symptoms but with relevant history of travel and/or contact or high risk of exposure. These include:	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.
D1	- Contact-traced individuals	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.
D2	- Healthcare workers, who shall be prioritized for regular testing in order to ensure the stability of our healthcare system	J	Economy Workers
D3	- Returning Overseas Filipino (ROF) workers, who shall immediately be tested at port of entry	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 Concern Areas, may be tested every three (3) months. These include but not limited to:
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		- 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)
E	Frontliners indirectly involved in health care provision in the response against COVID-19 may be tested as follows:		- Food Retail: waiters, waitress, bar attendants, baristas, chefs, cooks, restaurant managers
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		- Education: teachers at all levels of education and other school frontliners such as guidance counselors, librarians, cashiers
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		- Financial Services: bank tellers
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.		- Non-Food Retail: cashiers, stock clerks, retail salespersons
			- Services: hairdressers, barbers, manicurists, pedicurists, massage therapists, embalmers, morticians, undertakers, funeral directors, parking lot attendants, security guards, messengers
			- Construction: construction workers including carpenters, stonemasons, electricians, painters, foremen, supervisors, civil engineers, structural engineers, construction managers, crane/tower operators, elevator installers, repairmen
			- Water Supply, Sewerage, Waster Management: plumbers, recycling/ reclamation workers, garbage collectors, water/wastewater engineers, janitors, cleaners
		J2	- Public Sector: judges, courtroom clerks, staff and security, all national and local government employees rendering frontline services in special concern areas
			- Mass Media: field reporters, photographers, cameramen
			All employees not covered above are not required to undergo testing but are encouraged to be tested every quarter. Private sector employees 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
<p>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</p>	<p>Patients manifesting with acute respiratory distress syndrome, sepsis and/or septic shock:</p> <ol style="list-style-type: none"> 1. Acute Respiratory Distress Syndrome (ARDS) <ol style="list-style-type: none"> 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 2. Sepsis <ol style="list-style-type: none"> 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 b. Children with suspected or proven infection and > 2 age-based systemic inflammatory response syndrome criteria (abnormal temperature $> 38.5^{\circ}\text{C}$ or $< 36^{\circ}\text{C}$); tachycardia for age or bradycardia for age if < 1 year; 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 3. Septic Shock <ol style="list-style-type: none"> a. Adults with persistent hypotension despite volume resuscitation, requiring vasopressors to maintain MAP > 65 mmHg and serum lactate level > 2mmol/L b. Children with any hypotension (SBP < 5th 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.
<p>MODERATE</p> <ol style="list-style-type: none"> 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) 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) 	
<p>SEVERE</p> <ol style="list-style-type: none"> 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 2. Child with clinical signs of pneumonia (cough or difficulty in breathing) plus at least one of the following: <ol style="list-style-type: none"> 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. b. Fast breathing (in breaths/min): < 2 months: > 60; 2-11 months: > 50; 1-5 years: > 40. 	