<table>
<thead>
<tr>
<th>Clinical Features</th>
<th>Epidemiologic Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever or signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath)</td>
<td>AND Any person, including health care workers, who has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset</td>
</tr>
<tr>
<td>Fever and signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization</td>
<td>AND A history of travel from affected geographic areas (see below) within 14 days of symptom onset</td>
</tr>
<tr>
<td>Fever with severe acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization and without alternative explanatory diagnosis (e.g., influenza)</td>
<td>AND No source of exposure has been identified</td>
</tr>
</tbody>
</table>

Affected Geographic Areas with Widespread or Sustained Community Transmission

Last updated February 26, 2020

- China
- Iran
- Italy
- Japan
- South Korea

The criteria are intended to serve as guidance for evaluation. In consultation with public health departments, patients should be evaluated on a case-by-case basis to determine the need for testing. Testing may be considered for deceased persons who would otherwise meet the PUI criteria.
Footnotes

1Fever may be subjective or confirmed

2For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available in CDC’s Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19).

3Close contact is defined as—
a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case
– or –
b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.

Additional information is available in CDC’s updated Interim Infection Prevention and Control Recommendations for Patients with Confirmed COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings.

Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to healthcare personnel exposed in healthcare settings as described in CDC’s Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with COVID-19.

4Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.

5Affected areas are defined as geographic regions where sustained community transmission has been identified. Relevant affected areas will be defined as a country with at least a CDC Level 2 Travel Health Notice. See all COVID-19 Travel Health Notices.

6Category includes single or clusters of patients with severe acute lower respiratory illness (e.g., pneumonia, ARDS) of unknown etiology in which COVID-19 is being considered.