



Please fax this report for any POSITIVE COVID-19 cases identified through your facility. Enter as much information as you have available.

Date Completed: ___/___/___ Name: _____ Contact Number: (____) _____

Positive COVID-19 Report form

PATIENT	Last name: _____ First name: _____ DOB: ___/___/___ Address: _____ Patient Phone: (____) _____ Primary language: _____ Employed: <input type="checkbox"/> No <input type="checkbox"/> Yes, where: _____ High Risk? <input type="checkbox"/> No <input type="checkbox"/> Yes, detail: _____ Works/volunteers in high risk setting? <input type="checkbox"/> No <input type="checkbox"/> Yes, detail: <input type="checkbox"/> Hospital <input type="checkbox"/> LTC/ALF <input type="checkbox"/> Other: _____ If patient lives in a dorm setting, indicate: Dorm name: _____ Room# _____		
	EPIDEMIOLOGY	<input type="checkbox"/> Asymptomatic (no symptoms) First Symptom Onset: ___/___/___ <i>(check all that apply)</i> <input type="checkbox"/> Fever, Date: ___/___/___ If recorded, highest temp _____ °F <input type="checkbox"/> Cough, Date: ___/___/___ <input type="checkbox"/> Shortness of Breath or difficulty breathing	<input type="checkbox"/> Body aches <input type="checkbox"/> Chills <input type="checkbox"/> Sore Throat <input type="checkbox"/> Sinus Congestion <input type="checkbox"/> Pneumonia <input type="checkbox"/> Diarrhea
Was the patient hospitalized due to this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
EXPOSURE HISTORY	Did the patient have a known exposure 1-14 days before symptoms onset (or likely past exposure if asymptomatic)? <input type="checkbox"/> Unk <input type="checkbox"/> No <input type="checkbox"/> Yes, detail below: <input type="checkbox"/> Confirmed COVID-19 case (Name of case if known: _____) <input type="checkbox"/> Healthcare <input type="checkbox"/> Public venue Date of first exposure: ___/___/___ Date of last exposure: ___/___/___ Details:		
	Travel 1-14 days before symptoms onset (or relevant past travel history if asymptomatic)? <input type="checkbox"/> Unk <input type="checkbox"/> No <input type="checkbox"/> Yes, detail below: Travel destination: _____ Arrival date: ___/___/___ Return date: ___/___/___ Details:		
LAB RESULTS	Please fax copy of lab results with this report if available.		
	COVID-19 Test	Result	Collection Date
	PCR/EIA <input type="checkbox"/> Rapid	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv <input type="checkbox"/> Not done <input type="checkbox"/> Pending	___/___/___
	Antigen <input type="checkbox"/> OTC	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv <input type="checkbox"/> Not done <input type="checkbox"/> Pending	___/___/___
Other:	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv <input type="checkbox"/> Not done <input type="checkbox"/> Pending	___/___/___	
NOTES	_____ _____ _____		

