simcoe muskoka
DISTRICT HEALTH UNIT

COVID-19 Reporting Form

Case ID#:_____

Caller Information

Report taken by:	Date & time: yyyy / mm / dd time:
Name of Reporting Facility:	
Name of Reporting Person:	Contact Number: ( )

Patient Information

Patient's Name:	Health Card #:	DOB: yyyy / mm / dd	Gender: ☐ M ☐ F
Address:		Client Phone:	
City:		Postal Code:	
Family Physician:			

COVID Immunization

COVID Vaccine received: Dose #1 _____ **Dose #2**_____

Lab Information

Specimen Collected: ☐ NP ☐ Throat ☐ Sputum ☐ No sample collected Date Collected:

Signs and Symptoms
Tick all that apply and specify dates of presentation if known

☐ Fever
☐ cough
☐ sore throat
☐ difficulty breathing
☐ pneumonia
☐ Other please list

Other symptoms:

Exposures and Travel History

Exposures: ☐ Travel ☐ Exposure to case

Travel History:

Dates and Countries visited: _____

_____

_____

Hospital Visit Information

Attending Physician Name: _____

If **ADMIITTED** to hospital: Date of Admission: _____ Date of Discharge: _____

If **NOT ADMITTED**: Date of Hospital Visit: _____

If **TRANSFERRED FROM** a facility: Facility Name: _____ Date: _____

If **TRANSFERRED TO** a facility: Facility Name: _____ Date: _____

Additional Notes:

_____

_____

_____

****All completed forms to be faxed to the ID Confidential fax line at: 705-733-7738**