 COVID-19 Facility Reporting Form

Case ID#: \_**Click or tap here to enter text.**

OB#: \_**Click or tap here to enter text.**\_\_\_\_\_\_\_\_

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| --- |
| **Caller Information**  |
| Report taken by: **Click or tap here to enter text.** |  Date & time: **Click or tap to enter a date.** time:**Click or tap here to enter text.** |
| Name of Reporting Facility: **Click or tap here to enter text.** |
| Name of Reporting Person: **Click or tap here to enter text.** |  Contact Number: **Click or tap here to enter text.** |
| **Case’s Information** |
| Case’s Name:**Click or tap here to enter text.**  | Health Card #: (if available)**Click or tap here to enter text.** | DOB: **Click or tap to enter a date.** | Gender: [ ]  M [ ]  F [ ]  X |
| Address: **Click or tap here to enter text.**  | Phone #: **Click or tap here to enter text.** |
| City: **Click or tap here to enter text.** Postal Code: **Click or tap here to enter text.** |
| **Case’s Role at Facility**: [ ]  **Staff** [ ]  **Resident/Attendee** [ ]  **Essential visitor** [ ]  **Other: Click or tap here to enter text.**  |
| **COVID-19 Immunization** |
| **COVID Vaccine received:** [ ]  Unvaccinated/partially vaccinated [ ]  Fully vaccinated [ ]  Booster Dose #3 [ ]  Booster Dose #4  |
|  |
| **Congregate Setting Information**  |
| **Congregate Name: Click or tap here to enter text.** | **City: Click or tap here to enter text.** |
| **Congregate Address: Click or tap here to enter text.** | **Postal Code: Click or tap here to enter text.** |
| **Manager/Best contact for this address: Click or tap here to enter text.** | **Number: Click or tap here to enter text.** |
| **Testing Information** |
| **Date Collected:** **Specimen Collected:** [ ]  PCR – lab based [ ]  PCR – rapid molecular [ ]  Rapid Antigen Test (RAT) [ ]  Symptomatic - no sample collected **Date Collected**: (if second sample was completed) **Specimen Collected:** [ ]  PCR – lab based [ ]  PCR – rapid molecular [ ]  Rapid Antigen Test (RAT) [ ]  Symptomatic - no sample collected **Dates onsite during period of communicability:**  |
| **Signs and Symptoms**Tick all that apply and specify dates of presentation if known    |
|  [ ]  fever |  | [ ]  runny nose/nasal congestion | **Other symptoms: Click or tap here to enter text.** |
|  [ ]  cough |  | [ ]  headache |
|  [ ]  loss of taste/smell |  | [ ]  sore throat |
|  [ ]  shortness of breath/difficulty breathing [ ]  extreme fatigue |  | [ ]  muscle aches/joint pain[ ]  gastrointestinal symptoms |
| **Exposures History** |
| **Exposures:** [ ]  Travel [ ]  Household/community exposure to case [ ]  Facility exposure to case |
| **Acute Care Visit Information** |
| Acute Care Name: **Click or tap here to enter text.**Attending Physician Name: **Click or tap here to enter text.**If **ADMITTED** to hospital: Date of Admission: **Click or tap here to enter text.** Date of Discharge: **Click or tap here to enter text.**If **NOT ADMITTED**: Date of Hospital Visit: **Click or tap here to enter text.**If **TRANSFERRED FROM** a facility: Facility Name: **Click or tap here to enter text.** Date: **Click or tap to enter a date.**If **TRANSFERRED TO** a facility: Facility Name: **Click or tap here to enter text.** Date: **Click or tap to enter a date.** |
| **Additional Notes**: **Click or tap here to enter text.** |
| **\*\*All completed forms to be faxed to the ID Confidential fax line at: 705-733-7738** |