 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** | | | | | |