simcoe muskoka
DISTRICT HEALTH UNIT

COVID-19 LTCH Resident Initial Reporting Form

Case ID#:_____

Outbreak Number

Outbreak Number: 2260-2020-_____

Reporting Information

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

Patient Information

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

Signs and Symptoms

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

Symptom	Onset	Symptom	Onset	Symptom	Onset
☐ Fever		☐ Lost of Smell		☐ Other, please list	
☐ Cough		☐ Lost of Taste			
☐ Sore Throat		☐ Headache			
☐ Runny Nose		☐ Fatigue/Malaise			
☐ Difficulty Breathing		☐ Altered Mental Stat			
☐ Tachypnea		☐ Asymptomatic			

Risk Factors

Medical Risk Factor	Yes	No	Specify	Medical Risk Factor	Yes	No	Specify
Asthma				Diabetes			
COPD				Neurologic Disorder			
Cancer				Obesity			
Immunocompromised				Renal conditions			
Tuberculosis				Chronic Liver Disease			
Anemia or Hemoglobinopathy				Cardiovascular Conditions			
Chronic Illness / Underlying Medical Condition				Other			

Client Status & Complications

Complications		Hospitalized: □ Yes □ No	Death □ Yes □ No
☐ ARDS/Resp Failure	☐ Encephalitis	Date:	Date:
☐ Pneumonia	☐ Heart Arrhythmia/Failure	Hospital:	Cause of Death:
☐ Renal/Liver Failure	☐ Other	ICU □ Yes □ No	

Notes

****All completed forms to be faxed to the ID Confidential fax line at: 705-725-8007**