COVID-19 Case Report Form

Please complete this form for laboratory confirmed COVID-19 patient. Fax form to 1-800-233-1817.

REPORTER INFORMATION

Today's Date: _____/_____/_____ Hospital/Clinic: _____

Clinician Name: _____ Phone: _____

Disease Reporter's Name:_____ Phone: _____

COVID-19 TESTING INFORMATION

Lab Name: _____ Specimen Collection Date: _____/_____/_____

Test type

PCR/molecular: ☐ Positive ☐ Negative ☐ Not Done

Antigen requiring an instrument (Quidel Sofia, Becton-Dickinson Veritor and LumiraDx): ☐ Positive ☐ Negative ☐ Not Done

Antigen without an instrument (Abbott BinaxNOW Ag card): ☐ Positive ☐ Negative ☐ Not Done

PATIENT INFORMATION

First Name: _____ Last Name: _____ Phone: _____

Address: _____ City: _____

Zip Code: _____ County: _____ State: _____

Date of Birth: _____/_____/_____ Age: _____ **Years/Months** Sex: ☐ **Male** ☐ **Female**

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Does the patient work in a healthcare facility or congregate setting (e.g., long-term care or assisted living facility, shelter, prison, jail)

☐ YES ☐ NO Facility Name:_____
Employee Occupation:_____

Does the patient live in a congregate setting? (e.g., long-term care or assisted living facility, shelter, group home, prison, jail)

☐ YES ☐ NO Facility Name:_____

Does the patient attend school or childcare?

☐ YES ☐ NO School/Childcare Name and City:_____

CLINICAL INFORMATION

Date of symptom onset: _____/_____/_____ OR ☐ Asymptomatic

Is patient hospitalized? ☐ Y ☐ N ☐ Y ☐ N Pregnant?

☐ Y ☐ N ICU Admission? ☐ Y ☐ N Deceased?

Admit Date: _____/_____/_____ Date of death: _____/_____/_____

Discharge Date: _____/_____/_____

Hospital Name: _____