

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: _____