SOLANO PUBLIC HEALTH

Fax with lab result to: 707-429-4799

Internal Use Only

PUI ID:_____

CalREDIE ID:_____

COVID-19 Case Report Form

(May 12, 2020)

Patient Demographics

First Name: _____ **Last Name**: _____ DOB (MM/DD/YYYY): _____/_____/_____

Address: _____ City: _____ **Zip**: _____

Phone: _____ **Email**: _____

Sex: □ Male □ Female □ Intersex □ Unknown

Race/ethnicity (check all that apply):

□ Asian (choose at least one):
- □ Asian Indian □ Bangladeshi
- □ Chinese □ Filipino
- □ Hmong □ Indonesian
- □ Japanese □ Korean
- □ Malaysian □ Pakistani
- □ Sri Lankan □ Taiwanese
- □ Thai □ Vietnamese
- □ Other Asian □ Unknown

□ Hispanic/Latinx (choose at least one):
- □ Caribbean □ Central American
- □ Mexican/Mexican American/Chicano
- □ Puerto Rican □ South American
- □ Other Hispanic/Latinx □ Unknown

□ Native Hawaiian/ Pacific Islander (choose at least one):
- □ Chamorro/Guamanian □ Fijian
- □ Native Hawaiian □ Samoan □ Tongan
- □ Other Pacific Islander □ Unknown

□ American Indian/ Alaskan Native

□ Black

□ Middle Eastern

□ North African

□ White

□ Mixed Race

□ Unknown

SOS (Sensitive Occupations & Settings)—High priority for reporting

Please check all that apply:

□ Long-term care/senior living facility resident or worker □ Chronically homeless □ Healthcare worker

□ Correctional facility resident or worker □ Daycare worker □ First responder □ None of the above

Facility/Agency Name:_____ Address:_____

Reporting Health Care Provider and Agency: _____

Address: _____ Phone: _____

Where was testing performed (Please include laboratory test result with form)**?** _____

Is/was the patient hospitalized?

□ No □ Yes If yes, hospital name: _____ Address: _____

□ ICU □ Intubation □ Mechanical Ventilation

Discharge to SNF likely? □ No □ Yes □ Unknown

Current location of patient:

□ Still hospitalized

□ Home, lives with: _____

□ Other: _____

Appropriateness for home isolation (minimum 10 days post symptom onset date) assessed? □ No □ Yes □ Unknown

Relevant comorbid conditions:_____

Exposure Risk:

□ Community contact with lab-confirmed COVID-19 case- patient □ Any healthcare contact with lab-confirmed COVID-19 case-patient

Symptom Onset Date (MM/DD/YYY): _____/_____/_____ □ Unknown

During this illness, did the patient experience any of the following symptoms?	Symptom Present?
Fever >100.4F (38C)	☐ Yes ☐ No ☐ Unk
Subjective fever (felt feverish)	☐ Yes ☐ No ☐ Unk
Cough (new onset or worsening of chronic cough)	☐ Yes ☐ No ☐ Unk
Shortness of breath (dyspnea)	☐ Yes ☐ No ☐ Unk
Sore throat	☐ Yes ☐ No ☐ Unk
Chills	☐ Yes ☐ No ☐ Unk
Muscle aches (myalgia)	☐ Yes ☐ No ☐ Unk
Diarrhea (≥3 loose/looser than normal stools/24hr period)	☐ Yes ☐ No ☐ Unk
Other, specify: _____	☐ Yes ☐ No ☐ Unk