

## INSTITUTION COVID-19 TESTING REPORTING FORM

Complete a separate form for RESIDENTS and STAFF CASES. Fax daily to the EOHU **before** 10 a.m.

**Check appropriate box:**     residents line listing     staff line listing

**Date:** \_\_\_\_\_

Outbreak control measures implemented:     YES     NO      Date implemented: (yyyy/mm/dd): \_\_\_\_\_

Facility name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact name: \_\_\_\_\_

Telephone: \_\_\_\_\_      Fax: \_\_\_\_\_

Case Identification						Symptoms (Check all that apply)								Specimens / Diagnostics								Reason for testing i.e.: S = Symptomatic C = Contact AR = Asymptomatic Roommate		
Case number (sequentially)	Name	Date of birth (yy/mm/dd)	Sex: M / F / Other	Onset date of symptoms	Date symptom free	Abnormal body temperature	Cough dry (D) Productive (P)	Shortness of breath	Sore throat	Runny nose (R) sneezing (S)	Nasal congestion	Hoarse voice	Difficulty swallowing	Atypical Symptoms*  (see legend below; use a comma between multiple symptoms)	Pneumonia (date of day)	If pneumonia, chest x-ray confirmed – Yes (Y) or No (N)	Hospitalization (date of day)	Date of death (mm/dd)	Nasopharyngeal swab	Location of test	Date of test		HCW self-isolate	

\*Atypical Symptoms legend:    1 = Fatigue / malaise    2 = Acute delirium    3 = Falls / function decline    4 = Nausea / vomiting    5 = Diarrhea / abdominal cramps    6 = Chills    7 = Headache    8 = Croup  
    9 = Exacerbation of chronic symptoms    A = Tachycardia    B = Decrease in blood pressure    C = Unexplained hypoxia <90%    D = Lethargy, difficulty feeding