**I COPY AND PASTE THE CDRSS HEADER IN THIS SECTION WITH THE PATIENT DEMOGRAPHICS and PRINT**

**NOVEL CORONAVIRUS - 2019 NCOV | Report for :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Test Date: 03/21/2020**

|  |  |
| --- | --- |
| Sign/Symptom | Illness Onset:\_\_\_\_\_\_\_\_\_,2020Last Fever/Symptom:\_\_\_\_\_\_\_\_\_,2020 |
| **ABDOMINAL PAIN** |  |
| **ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)** |  |
| **CHILLS** | **NOTES:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **CORYZA (RUNNY NOSE)** |  |
| **COUGH**  |  |
| **DIARRHEA** |  |
| **FEVER (GREATER THAN OR EQUAL TO 100.4F)** |  °F |
| **HEADACHE** |  |
| **MYALGIA (MUSCLE ACHES)** |  |
| **NAUSEA** |  |
| **PHARYNGITIS (SORE THROAT)** |  |
| **PNEUMONIA** |  |
| **SHORTNESS OF BREATH** |  |
| **SUBJECTIVE FEVER (FELT FEVERISH)** |  |
| **LOSS OF TASTE AND/OR SMELL** |  |
| **FATIGUE** |  |

**IS THE PATIENT A HEALTHCARE WORKER IN THE UNITED STATES?**

Yes No Unknown

**IS THE PATIENT EMPLOYED?**

Yes No Unknown

OCCUPATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LOCATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOES THE PATIENT HAVE A HISTORY OF BEING IN A HEALTHCARE FACILITY (AS A PATIENT, WORKER, OR VISITOR)?**

Yes No Unknown

**IS THE CASE ASSOCIATED WITH ANY OF THE FOLLOWING?**

**□LONG-TERM CARE FACILITY**

**□ACUTE CARE FACILITY**

**□OUTPATIENT FACILITY**

**□PHYSICIAN PRACTICE**

**□SCHOOL**

**□DAYCARE CENTER**

**□CORRECTIONAL FACILITY**

**□OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LOCATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IN THE 14 DAYS PRIOR TO ILLNESS ONSET, DID THE PATIENT:**

**TRAVEL?**

YesNo

 \***HAVE HOUSEHOLD CONTACT WITH A CONFIRMED COVID-19 CASE?**

YesNo

 **UNKNOWN EXPOSURE?**

YesNo

 **IS THE PATIENT A CURRENT SMOKER?**

YesNo

 **IS THE PATIENT A FORMER SMOKER?**

YesNo

**IS THE PATIENT PREGNANT?**

YesNo

 **ANY UNDERLYING CONDITIONS?**

YesNo

**IS THE PATIENT HOSPITALIZED?**

Yes No **DATE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DECEASED:** Yes No