CENTRAL MISSISSIPPI HEALTH SERVICES, Inc.

COVID-19 Patient Reporting Form

Please complete the following form for each patient that COVID-19 testing is requested for. If a positive COVID-19 case is identified, please fax this information to MSDH at (601) 576-7497.

REPORTER INFORMATION

Today's Date: _____ Clinic Location:_____

Provider Name: _____ Phone: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Address: _____ City: _____ County: _____

Phone: _____ Date of Birth: _____ Age: _____ Years/Months

Sex: Male/Female Race: _____ Ethnicity: _____

Additional information **required** prioritization of testing

Does the patient live in a congregate setting (e.g., long-term care, shelter, group home) ☐ Yes ☐ No

Facility Name: _____

Is the patient a healthcare worker who provides direct patient care? ☐ Yes ☐ No

Employment Location: _____

Did the patient work while ill? ☐ Yes ☐ No

SYMPTOMS

Date of symptom onset: ____/ _____/ _____

☐Fever	☐Chills	☐Abdominal Pain	☐Pneumonia
☐Cough	☐Headache	☐Diarrhea	☐ARDS
☐Shortness of Breath	☐Sore Throat	☐Vomiting	☐Muscle Aches

☐ Loss of Smell/Taste Sensation

EXPOSURE HISTORY

In the 14 days before symptom onset, did the patient:

☐ Yes ☐ No Travel (including within the U.S.)? Location: _____

Dates: _____

☐ Yes ☐ No Have close contact with a **lab confirmed** COVID-19 case while that case was ill?

If yes, Case Name: _____

CLINICAL INFORMATION

☐ Yes ☐ No Hospitalized? Admit Date: _____ Does the patient have underlying conditions?

Hospital Name: _____ ☐None ☐Immunocompromised

☐ Yes ☐ No ICU Admission? ☐Unknown ☐Pregnant

☐ Yes ☐ No Intubated? ☐Diabetes ☐Chronic Lung Disease

Created: 4.1.2020 by India F. Keys MSPH, MS
Modeled after MN Department of Health COVID-19 Form

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☐ Yes ☐ No Deceased? ☐Hypertension ☐Chronic Liver Disease

☐ Yes ☐ No Chest X-ray or CT? ☐Cardiac Disease ☐Chronic Kidney Disease

☐ Yes ☐ No ECMO ☐Other: _____

LABORATORY TESTING

☐ Yes ☐ No Has the patient been tested for influenza?

Result: ☐ Positive ☐ Negative

Test Type: ☐ Rapid Test ☐ PCR

☐ Yes ☐ No Has the patient been tested for any other viral respiratory illness?

Result: _____

COVID-19 TESTING

Specimen Type	Date Collected	Positive	Negative	Equivocal	Not Done
NP swab					
OP swab					
Sputum					
Other:					

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