COVID-19 REPORT FORM
SEVERE OR HIGH-RISK SETTING CASES

Philadelphia Department of Public Health
Division of Disease Control
Acute Communicable Disease Program
1101 Market St 12th Flr, Philadelphia, PA 19107
Telephone (215) 685-6740 Fax (215) 238-6947
Form Available at hip.phila.gov

Use this form to report suspected and confirmed cases of novel coronavirus that are: 1) severe infections (hospitalized for ≥24 hours or fatal), 2) residents and staff in high-risk congregate settings (e.g., nursing homes, assisted living, behavioral health facilities, shelters, group homes, etc.) or 3) healthcare or essential workers.

PATIENT INFORMATION

Report Date	Last Name	First Name	D.O.B.	Age (D, W, M, Y)	Sex
___/___/_____			___/___/_____		☐M ☐F

Street Address	City	Zip Code

Phone Number	Race ☐African-American ☐White ☐Asian ☐Pacific Islander ☐Native-American ☐Unknown ☐Other ______________	Hispanic or Latino ☐Y ☐N ☐DK	Pregnant ☐Y ☐N ☐DK

☐ Lives in congregate setting (Nursing home, shelter, behavioral health facility, etc) Specify Location:	☐ Works in congregate setting Specify Location:	☐ Healthcare/essential worker Specify Location:
☐ School/Daycare Specify Location:	☐ Travel outside of Philadelphia Location: ________________ Dates: ___/___/___to___/___/___	Close contact with person with COVID-19 ☐Y ☐N ☐DK

HOSPITALIZATION AND LABORATORY INFORMATION

HOSPITALIZATION

Y=Yes; N=No; DK=Don't Know

Hospital Name: ____________________

Medical Record #: ____________________

Admission Date: ____/____/_____ Discharge Date: ____/____/_____

Hospitalized for ≥ 24 hours: ☐ Y ☐ N ☐ DK

Diagnosing Physician: ____________________

Physician Phone #: ______________________

Airborne Infection Isolation Room? (Date:____/____/_____)

Admitted to ICU? ☐ Y ☐ N ☐ DK

Was mechanical ventilation received? ☐ Y ☐ N ☐ DK

Was ECMO received? ☐ Y ☐ N ☐ DK

Fatal? ☐ Y ☐ N ☐ DK (Date of Death:___/___/______)

LABORATORY (Check all POSITIVE results)

Performing Laboratory Name: ______________

Specimen Collection Date: ___/___/______

Source (if not nasopharynx): _____________

☐ SARS-CoV-2, RT-PCR
☐ SARS-CoV-2 Rapid Molecular Assay
☐ SARS-CoV-2 Rapid IgM/IgG Assay
☐ SARS-CoV-2 Rapid Antigen Assay
☐ SARS-CoV-2 Serology (IgM/IgG)
☐ Other SARS-CoV-2 Assay (specify: ____________________)

ADDITIONAL CLINICAL INFORMATION

SYMPTOMS

Onset Date: ___/___/______

☐ Fever, Highest temp (F): _________
☐ Abdominal Pain
☐ Chills
☐ Cough
☐ Diarrhea
☐ Headache
☐ Muscle Aches
☐ Shortness of Breath
☐ Runny Nose
☐ Nausea
☐ Vomiting
☐ Sore Throat
☐ Fatigue
☐ Other, Specify: _______________

MEDICAL COMPLICATIONS

☐ None ☐ Acute Respiratory Distress Syndrome (ARDS) ☐ Pneumonia (X-ray confirmed) ☐ Other, Specify: _______________

UNDERLYING CONDITIONS

☐ None
☐ Asthma
☐ Cardiovascular Disease
☐ Chronic Lung Disease (COPD/emphysema)
☐ Diabetes
☐ Immunosuppression, Specify: _______________
☐ Chronic Renal Disease
☐ Chronic Liver Disease
☐ Current Smoker
☐ Former Smoker
☐ Other, Specify: _______________

REPORTER INFORMATION

Facility Name	Reporter Name	Reporter Phone #	Title: ☐ ICP ☐ DO/MD ☐ PA/NP ☐ RN ☐ Other, Specify: _______________

Please fax report to (215) 238-6947 upon completion. If case is associated with a suspect outbreak, please indicate on form.