COVID-19 POSTIVE CASE REPORT

Please fax completed form to MCDH case investigator at 815-334-0191 (Secure)

DATE:

PATIENT INFORMATION -

NAME OF PATIENT:

DATE OF BIRTH:

PHONE

HOME:

CELL:

ADDRESS:

EMPLOYER:

CLINIC INFORMATION –

DATE OF ONSET:

DATE SPECIMEN COLLECTED:

SYMPTOMS:

DISPOSITION OF PATIENT (HOME/HOSPITAL):

CURRENT STATUS IF AVAILABLE:

COMORBIDITY LIST: