# New Hampshire Confidential COVID-19 Case Report Form v 3/15/2020

For Reporting Suspect and Confirmed Cases

Date of Report: _____/_____/_______

## Patient Information

Name ________________________________________________

(Last) ____________________________________________

(First) ___________________________________________

(M.I.) ____________________________________________

Date of Birth _____/_____/_________ Age ____________

Sex: □ Male □ Female □ Other

Address __________________________________________

City/Town ________________________________________

State _______ Zip _______

Phone: Cell ______________________ Home ______________

Work ______________________

Race: □ White □ Black □ Asian □ Pacific Islander □ Native Am./Alaskan Nat □ Unknown □ Other: ______

Ethnicity: □ Hispanic □ Not Hispanic □ Unknown

Occupation/Employment ____________________________

Employer: _______________________________________

Healthcare Worker: □ Yes □ No □ Unknown

Childcare Worker: □ Yes □ No □ Unknown

Is the patient a resident of a long-term care facility? □ Yes □ No □ Unknown

## Symptoms and Clinical Information

Symptom Onset Date: _____/_____/_______

□ Fever □ Cough □ Shortness of breath □ Other: __________

Is the patient hospitalized for their illness? □ Yes □ No □ Unknown

Hospital Location: ____________________________________

Dates: _____/_____/______ - _____/_____/______

Specimens Collected: □ No □ Yes Date: _____/_____/______

Laboratory: _______________________________________

## Risk Factors/Reason for Testing (check all that apply)

International Travel: ____________________________

□ Yes □ No □ Not asked □ Unknown

Domestic Travel: _______________________________

□ Yes □ No □ Not asked □ Unknown

Contact to a case: ______________________________

□ Yes □ No □ Not asked □ Unknown

No known risk factors: __________________________

□ Yes □ No □ Not asked □ Unknown

Notes: ______________________________________________________________________________________

## Health Care Provider Reporting Information

Person Completing Report Form __________________________

Ordering Provider ____________________________ Phone ______________________

Provider Facility/Practice Name __________________________

City/Town __________________________

State _______ Zip _______

Fax to: (603) 271-0545

NH Department of Health and Human Services

Bureau of Infectious Disease Control

Office Phone: 603-271-4496

For NH DHHS Use Only

□ Confirmed □ Not a case

□ Probable □ Entered in NHEDSS

□ Suspect □ Assigned to Investigator

□ Unknown