WISCONSIN COVID-19 PATIENT INFORMATION FORM

FIRST NAME: _____ LAST NAME: _____ DATE OF BIRTH: _____/_____/_____

GENDER: ☐M ☐F ☐OTHER_____ ☐UNKNOWN

RACE: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other____

ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic/Latino PREFERRED LANGUAGE: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ COUNTY: _____

PRIMARY PHONE (E.G. MOBILE): _____ SECONDARY PHONE: _____ EMAIL: _____

IS THE PERSON A HEALTH CARE WORKER? ☐ Yes ☐ No OCCUPATION: _____

REASON FOR TESTING (CHECK ALL THAT APPLY)

☐ SYMPTOMS OF COVID-19 ONSET DATE FOR EARLIEST SYMPTOM:____/_____/_____ ☐ ASYMPTOMATIC

Has the patient had any of the following symptoms in the **past 14 days**?

Fever	☐ Yes	☐ No	Muscle aches (myalgia)	☐ Yes	☐ No
Cough (new onset or worsening of chronic cough)	☐ Yes	☐ No	Fatigue	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No	Runny nose (rhinorrhea)	☐ Yes	☐ No
Shortness of breath (dyspnea)	☐ Yes	☐ No	Vomiting	☐ Yes	☐ No
Nausea	☐ Yes	☐ No	Diarrhea (>3 loose stools/day)	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No	Loss of smell?	☐ Yes	☐ No
Chills	☐ Yes	☐ No	Loss of taste?	☐ Yes	☐ No
Headache	☐ Yes	☐ No	Other, specify		

☐ Public Health Investigation (E.G. long-term care, workplace, corrections) – **Enter Investigation Details Below**

☐ Community Testing Site

☐ Hospitalized (inpatient): Admission Date: ICU: ☐ Yes ☐ No

☐ Pre-procedure or Preoperative Screening

RESIDENTIAL AND OCCUPATIONAL INFORMATION (REQUIRED FOR PUBLIC HEALTH INVESTIGATIONS)

Does the patient **work** in nursing home, long-term care facility, jail, shelter or other congregate living setting?

☐ YES ☐ NO If Yes, name and location of facility:

Does the patient **live** in nursing home, long-term care facility, jail, shelter or other congregate living setting?

☐ YES ☐ NO If Yes, name and location of facility:

If part of a **workplace investigation**, is the patient an EMPLOYEE? ☐ Yes ☐ No CONTACT OF AN EMPLOYEE? ☐ Yes ☐ No

What is the name of the workplace: What section or unit?

ORDERING PROVIDER AND FACILITY

COLLECTION DATE: SPECIMEN TYPE: ☐NASAL SWAB ☐NP ☐OP ☐ SALIVA ☐OTHER

ORDERING PROVIDER: _____ PHONE: _____

REPORTING FACILITY OR HEALTH DEPARTMENT: _____

INVESTIGATION NAME/ID (IF APPLICABLE FOR PUBLIC HEALTH INVESTIGATION): _____

All patients with a pending molecular test must be reported to public health while laboratory results are pending, and reports must include the data fields on this form. Reporting this information via WEDSS is strongly encouraged. In lieu of WEDSS reporting, this form can be used to report to the patient's local public health agency while results are pending. A list of local health agency contact information can be found on the Department of Health Services website.