Caller's name: ______________________________Phone number: ____________________Agency:_____________

Patient's First name:________________________ Last Name:___________________________

Date of birth: ____/____/____ Age: __________ Sex: Female / Male

Patient address: _______________________________ City:___________________ State:_____ Zip Code: ________

Patient phone number(s): _____________________ /_____________________

Patient's symptoms w/date of onset:

- ☐ Fever >100.4F (38C): how high? ________
- ☐ Subjective fever (felt feverish)
- ☐ Chills
- ☐ Muscle aches (myalgia)
- ☐ Runny nose (rhinorrhea)
- ☐ Sore throat
- ☐ Cough (new onset or worsening of chronic cough)
- ☐ Shortness of breath (dyspnea)
- ☐ Nausea or vomiting
- ☐ Headache
- ☐ Abdominal pain
- ☐ Diarrhea (≥3 loose/looser than normal stools/24hr period)
- ☐ Other:

Travel History - include dates of travel with any itinerary to the following:

- ☐ Mainland China
- ☐ Italy
- ☐ South Korea
- ☐ Iran
- ☐ Japan
- ☐ Other notable travel:

Contact with COVID-19 + Patient? ☐ YES ☐ NO

Rapid Flu: ☐ Negative

☐ Positive – Tamiflu:

☐ Patient ☐ Contacts/fam

R-pan/viral comp:

☐ YES ☐ NO

Results:

☐ Positive :____________

☐ Negative

CXR:

☐ Normal

☐ Abnormal:___________

Pre-existing conditions:

- ☐ Chronic Lung Disease (asthma/emphysema/COPD)
- ☐ Cardiovascular disease
- ☐ Chronic Renal disease
- ☐ Chronic Liver disease
- ☐ Immunocompromised Condition
- ☐ Neurologic/neurodevelopmental
- ☐ Other chronic diseases
- ☐ If female, currently pregnant
- ☐ Current smoker
- ☐ Former smoker
- ☐ Other HH:

NOTES:

NURSE:__________________________________ DATE:________________