Connecticut Department of Public Health
2019 Novel Coronavirus (COVID-19) Case Report Form

*Please complete the following information for all patients with a **laboratory-confirmed** diagnosis of COVID-19. Fax completed forms to DPH Epidemiology & Emerging Infections Program **860-629-6962**.*

PATIENT INFORMATION ***All dates in mm/dd/yyyy format.***

Name Last _____ First _____ Middle _____

Street Address_____

City_____ County_____ State_____ Zip _____

Phone: _____ **Date of Birth** _____

Race ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown ☐ Other, specify: _____
Ethnicity: Hispanic/Latino ☐ Yes ☐ No ☐ Unknown

Gender ☐ Female ☐ Male ☐ Other ☐ Unknown **If female**, pregnant? ☐ Yes ☐ No ☐ Unknown

Did patient reside or spend time in a congregate setting? ☐ Yes ☐ No
☐ Reside ☐ Attend ☐ Work in ☐ Volunteer
☐ Long term care facility/assisted living ☐ Homeless shelter ☐ Jail/prison ☐ Other
If yes, name of facility: _____ **Town:** _____

Is the patient a healthcare worker? ☐ Yes ☐ No
If yes, name of facility: _____ **Town:** _____

Were there any symptoms associated with this illness/event? ☐ Yes ☐ No ☐ Unknown
If symptomatic, date of onset _____
Symptoms ☐ Cough ☐ Fever ☐ Shortness of breath ☐ Fatigue ☐ Headache

Did the patient develop pneumonia? ☐ Yes ☐ No ☐ Unknown If yes, abnormal chest CT/x-ray: ☐

Was the patient hospitalized? ☐ Yes ☐ No ☐ Unknown
If yes, Hospital Name _____ MR# _____
Admission date:_____ Discharge date: _____
Was patient treated in the ICU? ☐ Yes ☐ No ☐ Unknown

Did patient die? ☐ No ☐ Yes (date of death: _____)

PROVIDER/REPORTER & FACILITY INFORMATION

Healthcare Provider: Last _____ First _____
Person Completing Report: Last _____ First _____
Facility Name: _____
Facility Address: _____
Phone Number: _____ **Fax Number:** _____
Email Address: _____

DPH USE

Case ID: _____ Report Date: _____
mm/dd/yyyy