

WISCONSIN COVID-19 PATIENT INFORMATION

First Name		Last Name		Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Race <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	Ethnicity <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other				Preferred language
Street Address		City	State	Zip	County
Primary Phone (e.g. cellphone)		Secondary Phone		Email Address	
Is Patient a healthcare worker? <input type="checkbox"/> Yes <input type="checkbox"/> 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**?

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

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](#).