Government of Northwest Territories | Gouvernement des Territoires du Nord-Ouest

COVID-19 REPORT FORM (SUSPECT CASE/PERSON UNDER INVESTIGATION)

Personal health information is being collected under the *NWT Health Information Act* and the *Public Health Act* and will not be used or disclosed, unless allowed or required by these Acts or any other Act

Date of Report: YYYY/MMM/DD ☐ Initial Report ☐ Updated Report ☐ SPOT Testing

Part A:

To be completed for all COVID-19 Suspect Cases/PUI

Return ***within 24 hours of specimen collection*** to the Office of the Chief Public Health Officer:
Secure Dropbox: **https://sft.gov.nt.ca/filedrop/~SXTSaO**
Confidential fax line: 867-873-0442

Patient Information (use patient label if possible)

HCP #:

Name:

Community/Country:

Date of Birth: YYYY/MMM/DD Sex: ☐ M ☐ F ☐ X

Phone # or best contact method:

Clinical Information ☐ **Asymptomatic**

Date of symptom onset: YYYY/MMM/DD

☐ Fever Temperature, if known:
☐ Cough
☐ Dyspnea ☐ Diarrhea/vomiting
☐ Headache ☐ Fatigue
☐ Sore Throat ☐ Malaise
☐ Myalgia ☐ Rhinorrhea
☐ Anosmia ☐ Other, specify:

Laboratory

Specimen Collection Date: YYYY/MMM/DD
☐ NP swab
☐ Throat swab
☐ Sputum
☐ Other (e.g. BAL), specify:

Travel History

Travel from:

Start date: YYYY/MMM/DD End date: YYYY/MMM/DD

Radiology – Imaging

Date: YYYY/MMM/DD
☐ Not Applicable
☐ No abnormalities suggestive of COVID-19
☐ Evidence of lower respiratory tract infection

Exposure History

Exposure to suspect, probable, or confirmed case? ☐ Yes ☐ No
Exposure details:

Date of last contact: YYYY/MMM/DD

Patient Setting

☐ Physician office/clinic ☐ Home visit
☐ ED (not admitted) ☐ Facility (LTC, Corrections)
☐ Inpatient (ward) Admission date: YYYY/MMM/DD
☐ Inpatient (ICU) Admission date: YYYY/MMM/DD

Reason for Testing

☐ Individual sought health care
☐ Routine respiratory disease surveillance
☐ Contact of a case
☐ Other, specify:

Disposition

☐ Stable ☐ Deteriorating
☐ Deceased Date of death: YYYY/MMM/DD

Other Information

Self-isolation advice given? ☐ Yes ☐ No
Received current season's flu vaccine (self-reported)? ☐ Yes ☐ No ☐ Unknown

Social Risk Factor

☐ Health Care Worker
☐ School/daycare worker OR attendee
☐ Lab worker/handles biological specimens
☐ Resident of LTC/Institution:
☐ Experiencing Homelessness
☐ Other, specify:

Pre-existing Conditions

Pregnancy ☐ Yes ☐ No ☐ Not asked
If yes, trimester:
Post-partum (≤6 weeks) ☐ Yes ☐ No ☐ Not asked
Chronic health condition ☐ Yes ☐ No ☐ Not asked
If yes, specify:

Health Service Provider Information

Name:

Signature:

Clinic:

Date: YYYY/MMM/DD

Updated: April 27, 2020