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

# COVID-19 REPORT FORM (FOR ALL CASES)

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 ☐ Assessed in-person ☐ Assessed by virtual care

## Part B:

**To be completed for all COVID-19 Confirmed, Epi-linked and Probable Cases**

Return ***within 24 hours of lab results*** or ***if directed*** 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 Update ☐ Asymptomatic

Additional symptom onset? ☐ Yes ☐ No
Date of symptom update: YYYY/MMM/DD

Temperature, if known:

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

### Pre-existing Conditions & Risk Factors

☐ Yes ☐ No ☐ Not asked Cardiac Disease
☐ Yes ☐ No ☐ Not asked Chronic neurological
☐ Yes ☐ No ☐ Not asked Neuromuscular Disorder
☐ Yes ☐ No ☐ Not asked Diabetes
☐ Yes ☐ No ☐ Not asked Immunocompromised
☐ Yes ☐ No ☐ Not asked Liver Disease
☐ Yes ☐ No ☐ Not asked Malignancy
☐ Yes ☐ No ☐ Not asked Renal Disease
☐ Yes ☐ No ☐ Not asked Respiratory Disease

### Patient Setting Update

☐ Self-Isolation
☐ Facility (LTC, Corrections) Specify:
☐ Inpatient (ward) Admission date: YYYY/MMM/DD
☐ Inpatient (ICU) Admission date: YYYY/MMM/DD
☐ Experiencing Homelessness

### Signs & Symptoms

☐ Yes ☐ No ☐ Not asked Acute Respiratory Distress Syndrome
☐ Yes ☐ No ☐ Not asked Abnormal lung auscultation
☐ Yes ☐ No ☐ Not asked Altered mental status
☐ Yes ☐ No ☐ Not asked Clinical or radiological evidence of pneumonia
☐ Yes ☐ No ☐ Not asked Coma
☐ Yes ☐ No ☐ Not asked Conjunctival Injection
☐ Yes ☐ No ☐ Not asked Dyspnea
☐ Yes ☐ No ☐ Not asked Encephalitis
☐ Yes ☐ No ☐ Not asked Hypotension
☐ Yes ☐ No ☐ Not asked Pharyngeal exudate
☐ Yes ☐ No ☐ Not asked Renal Failure
☐ Yes ☐ No ☐ Not asked Seizure
☐ Yes ☐ No ☐ Not asked Sepsis
☐ Yes ☐ No ☐ Not asked Tachypnea (accelerated respiratory rate)
☐ Yes ☐ No ☐ Not asked Other:

### Disposition Update

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

### Health Service Provider Information

Name: Clinic:

Signature: Date: YYYY/MMM/DD