North Dakota Department of Health **COVID-19 EVALUATION AND TEST REPORT FORM**

CDC 2019-nCoV ID: ________________

North Dakota ID: ________________

Providers MUST fill out this form and submit with every patient being tested for COVID-19 at the NDDoH. This form MUST be submitted with the specimen. Testing priority is based on the clinical and epidemiological risk information provided. Specimens submitted without this completed form will fall to the bottom of the testing queue.

Revised: 3/16/2020

PATIENT INFORMATION

First Name:	Last Name:	Date of Birth:	
Street Address:	City:	State:	ZIP Code:
Telephone Number:	Gender: ☐ Male ☐ Female ☐ Unknown ☐ Other Gender ____________________		
Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ____________________		Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused	
Healthcare Provider:		Healthcare Facility:	

CLINICAL & SOCIAL HISTORY

Question	Response	Details
Was/Is the patient hospitalized?	☐ Yes ☐ No	Admission Date: Discharge Date:
Was/is the patient admitted to an intensive care unit (ICU)? **§**	☐ Yes ☐ No	
Had/has the patient received mechanical ventilation (MV)/intubation?	☐ Yes ☐ No	If yes, total MV days:
Did/does the patient have pneumonia during this illness?	☐ Yes ☐ No	
Did/does the patient have acute respiratory distress syndrome?	☐ Yes ☐ No	
Did/does the patient have an abnormal chest x-ray?	☐ Yes ☐ No	
Is the patient pregnant?	☐ Yes ☐ No	If yes, Due Date:
Is the patient a health care worker or work within a healthcare facility in the United States? **§**	☐ Yes ☐ No	Role and Location:
Does the patient have pre-existing medical conditions?	☐ Yes ☐ No	Describe:
Does the patient reside in an institutional setting? (e.g. Long-term or basic care facility, group home, corrections, etc.) **§**	☐ Yes ☐ No	Location:
Does the patient have a history of travel from a geographic area* (domestic or international) with sustained community COVID-19 transmission within the last 14 days?	☐ Yes ☐ No	Location: Dates of Travel: Date of Arrival to US:
Does the patient report close contact with a confirmed COVID-19 patient within the last 14 days? **§**	☐ Yes ☐ No	Location and/or Person: Date of Exposure:

* See the CDC website for areas with sustained community COVID-19 transmission:

International - www.cdc.gov/coronavirus/2019-ncov/travelers/index.html

Domestic - https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html

For states with demonstrated community spread, click on the + sign below the States Reporting Cases Map at the link listed.
Cruise ships are unique environments where close person-to-person contact occurs and may be considered if known positives onboard.

§ If YES is selected, please call the NDDoH at 800-472-2180 to arrange for **expedited specimen delivery** to the NDDoH.

Providers should consider patient symptoms, severity of illness (e.g., ICU patient), and alternative diagnoses (e.g., influenza, allergies) along with epidemiologic risk and potential exposure to highly-susceptible populations and use their clinical judgment on who should be tested for COVID-19 infection. All patients being tested for COVID-19 will need to be isolated (at home or in a hospital) while awaiting test results. Appropriate personal protective equipment (PPE) and isolation precautions should be adhered to during specimen collection.

North Dakota Department of Health **COVID-19**

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During this illness, did the patient experience any of the following symptoms? First symptom Onset Date:	
Fever >100.4 ºF (38 ºC) Fever Onset Date: ___________ Highest Measured Temperature: __________ ☐ ºF ☐ ºC	☐ Yes ☐ No
Subjective fever (felt feverish)	☐ Yes ☐ No
Chills	☐ Yes ☐ No
Muscle Aches (myalgia)	☐ Yes ☐ No
Runny Nose (rhinorrhea)	☐ Yes ☐ No
Sore Throat	☐ Yes ☐ No
Cough (new onset or worsening of chronic cough)	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No
Nausea or Vomiting	☐ Yes ☐ No
Headache	☐ Yes ☐ No
Abdominal Pain	☐ Yes ☐ No
Diarrhea (≥ 3 loose/looser than normal stools/24hrs)	☐ Yes ☐ No
Other, specify ___________________________	☐ Yes ☐ No

Respiratory Diagnostic Testing		**Date of Testing**
Influenza rapid antigen ☐ A ☐ B	☐ Pos ☐ Neg ☐ Pend ☐ Not Done	
Influenza PCR ☐ A ☐ B	☐ Pos ☐ Neg ☐ Pend ☐ Not Done	
RSV	☐ Pos ☐ Neg ☐ Pend ☐ Not Done	
Human metapneumovirus	☐ Pos ☐ Neg ☐ Pend ☐ Not Done	
Parainfluenza (1-2)	☐ Pos ☐ Neg ☐ Pend ☐ Not Done	
Adenovirus	☐ Pos ☐ Neg ☐ Pend ☐ Not Done	
Rhinovirus/enterovirus	☐ Pos ☐ Neg ☐ Pend ☐ Not Done	
Coronavirus (OC43, 229E, HKU1, NL63)	☐ Pos ☐ Neg ☐ Pend ☐ Not Done	
M. pneumoniae	☐ Pos ☐ Neg ☐ Pend ☐ Not Done	
C. pneumoniae	☐ Pos ☐ Neg ☐ Pend ☐ Not Done	
Other, specify ______________	☐ Pos ☐ Neg ☐ Pend ☐ Not Done	