

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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other Gender _____		
Race: <input type="checkbox"/> American Indian/Alaskan 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 _____		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Refused	
Healthcare Provider:		Healthcare Facility:	

CLINICAL & SOCIAL HISTORY

Was/Is the patient hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Admission Date: Discharge Date:
Was/is the patient admitted to an intensive care unit (ICU)? §	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Had/has the patient received mechanical ventilation (MV)/intubation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, total MV days:
Did/does the patient have pneumonia during this illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did/does the patient have acute respiratory distress syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did/does the patient have an abnormal chest x-ray?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the patient pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Due Date:
Is the patient a health care worker or work within a healthcare facility in the United States? §	<input type="checkbox"/> Yes <input type="checkbox"/> No	Role and Location:
Does the patient have pre-existing medical conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:
Does the patient reside in an institutional setting? (e.g. Long-term or basic care facility, group home, corrections, etc.) §	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? §	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

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

Respiratory Diagnostic Testing	Date of Testing
Influenza rapid antigen <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done
Influenza PCR <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done
RSV	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done
Human metapneumovirus	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done
Parainfluenza (1-2)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done
Adenovirus	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done
Rhinovirus/enterovirus	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done
Coronavirus (OC43, 229E, HKU1, NL63)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done
<i>M. pneumoniae</i>	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done
<i>C. pneumoniae</i>	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done
Other, specify _____	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done