DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-02700 (Last Revised 07/22/2020)

STATE OF WISCONSIN

WISCONSIN COVID-19 PATIENT INFORMATION

First Name	Last Name	Date of Birth	Gender
			☐ M ☐ F ☐ Other ☐ Unknown

Race	Ethinicity	Preferred language
☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other	

Street Address	City	State	Zip	County

Primary Phone (e.g., cellphone)	Secondary Phone	Email Address

Is Patient a health care worker? ☐ Yes ☐ 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	☐	☐	Muscle aches (myalgia)	☐	☐
Cough (new onset or worsening of chronic cough)	☐	☐	Fatigue	☐	☐
Sore throat	☐	☐	Runny nose (rhinorrhea)	☐	☐
Shortness of breath (dyspnea)	☐	☐	Vomiting	☐	☐
Nausea	☐	☐	Diarrhea (more than 3 loose stools/day)	☐	☐
Abdominal pain	☐	☐	Loss of smell?	☐	☐
Chills	☐	☐	Loss of taste?	☐	☐
Headache	☐	☐	Other, specify _____	☐	☐

☐ 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.