Sarah Bush Lincoln

Community COVID-19 Order/PUI Form

Name: _____ **DOB:** _____/_____/_____

Local Address: _____ Sex: ☐ Male ☐ Female

City: _____ **State:** _____ **Zip Code:** _____

Phone: (_____) _____-_____

COUNTY: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐ White ☐ African American/Black ☐ Native American ☐ Asian/Pacific Islander ☐ Other ☐ Unknown

First test?
- ☐ Yes
- ☐ No
- ☐ Unknown

Hospitalized?
- ☐ Yes
- ☐ No
- ☐ Unknown

ICU?
- ☐ Yes
- ☐ No
- ☐ Unknown

Congregate Living?
Nursing home, residential care for people with intellectual and developmental disabilities, psychiatric treatment facility, group home, board and care home, homeless shelter, foster care, other:
- ☐ Yes
- ☐ No
- ☐ Unknown

Employed in healthcare?
- ☐ Yes
- ☐ No
- ☐ Unknown

Law Enforcement?
- ☐ Yes
- ☐ No
- ☐ Unknown

EMS/First Responders?
- ☐ Yes
- ☐ No
- ☐ Unknown

Pregnant?
- ☐ Yes
- ☐ No
- ☐ Unknown

Symptomatic as defined by CDC?*
- ☐ Yes
- ☐ No
- ☐ Unknown

Date of Symptom Onset:

_____
mm / dd / yy

***Symptoms:** (check all that apply)

- ☐ Fever or chills
- ☐ Cough
- ☐ Shortness of breath or difficulty breathing
- ☐ Fatigue
- ☐ Muscle or body aches
- ☐ Headache
- ☐ New loss of taste or smell
- ☐ Sore throat
- ☐ Congestion or runny nose
- ☐ Nausea or vomiting
- ☐ Diarrhea

Collected Date: _____

Collected Time: _____

Source:
- ☐ Nasopharyngeal
- ☐ Nasal
- ☐ _____