Reset | Print form

Coronavirus
COVID-19

Orpheus ID

☐ Confirmed ☐ Presumptive ☐ Suspect ☐ No case

Name _____ County _____
LAST, first, initials (a.k.a.)

High Risk
- ☐ **Lives in LTC/Assisted Living/Memory Care
- ☐ **Works in LTC/Assisted Living/Memory Care
- ☐ **Works in healthcare/EMS
- ☐ **Works in jail or correctional facility
- ☐ **Lives in jail or correctional facility
- ☐ **Unstably housed/homeless
- ☐ Elderly (≥60 years of age)
- ☐ Immunocompromised
- ☐ Pregnant
- ☐ Works with vulnerable populations

** ***If YES*** to any of these, contact your CD Nurse once interview is complete.

Address _____ _____ _____
Street City Zipcode

If Congregate setting, List type LTC _____
Point of Contact: _____
If unstably housed, give details: _____

Phone number _____ / _____
☐ home ☐ work ☐ cell ☐ msg ☐ home ☐ work ☐ cell ☐ msg

E-mail _____ Preferred Communication _ snail mail _____

ALTERNATE CONTACT

_____ _____
LAST, first, initials ☐ home ☐ work ☐ cell ☐ msg

DEMOGRAPHICS

DOB _____ if DOB unknown, AGE _____ Preg ☐ Y ☐ N ☐ UNK
Sex (Current/case) _ Refused _ Sex (Birth/person) _ Unknown _ Gender _ Refused

Language _____ Country of birth _____ ☐ refugee

Worksites/school/day care center _____ Grade _____

Occupation. _____ Industry _____

BASIS OF DIAGNOSIS

CLINICAL DATA

Symptomatic ☐ yes ☐ no ☐ ref ☐ unk
if yes, ONSET on _____
diagnosis date _____ ☐ onset indeterminate

Check all that apply: **(Provide details in Notes below.)**

Fever (>100.4F) _____	☐ yes	☐ no	☐ ref	☐ unk
Subjective fever (feverish)	☐ yes	☐ no	☐ ref	☐ unk
Any cough	☐ yes	☐ no	☐ ref	☐ unk
Shortness of breath (dyspnea)	☐ yes	☐ no	☐ ref	☐ unk
Loss of sense of taste/smell	☐ yes	☐ no	☐ ref	☐ unk
Pneumonia	☐ yes	☐ no	☐ ref	☐ unk
Chills	☐ yes	☐ no	☐ ref	☐ unk
Muscle aches (myalgia)	☐ yes	☐ no	☐ ref	☐ unk
Headache	☐ yes	☐ no	☐ ref	☐ unk
Runny nose (rhinorrhea)	☐ yes	☐ no	☐ ref	☐ unk
Sore throat	☐ yes	☐ no	☐ ref	☐ unk
Nausea	☐ yes	☐ no	☐ ref	☐ unk
Vomiting	☐ yes	☐ no	☐ ref	☐ unk
Abdominal Pain	☐ yes	☐ no	☐ ref	☐ unk
Diarrhea (>3 /24 hours)	☐ yes	☐ no	☐ ref	☐ unk
Abnormal chest Xray	☐ yes	☐ no	☐ ref	☐ unk
ARDS (per medical record)	☐ yes	☐ no	☐ ref	☐ unk
Mechanical ventilation	☐ yes	☐ no	☐ ref	☐ unk
Received ECMO	☐ yes	☐ no	☐ ref	☐ unk

OUTCOMES

Did patient have any other diagnosis or identified co-infections to explain illness? ☐ yes ☐ no ☐ unk
if *yes,* specify below

_____
++

Hospitalized: ☐ yes ☐ no ☐ unk
Hospital 1 Name _____
Chart number _____
Admit date _____ Discharge date _____
Status: ☐ alive ☐ dead ☐ unk ☐ transfer
ICU: unk ICU admit _____ ICU discharge _____
Ventilator: Unk intubation _____ extubation _____
++

Hospitalized: ☐ yes ☐ no ☐ unk
Hospital 2 Name _____
Chart number _____
Admit date _____ Discharge date _____
Status: : ☐ alive ☐ dead ☐ unk ☐ transfer
ICU: Unk ICU admit _____ ICU discharge _____
Ventilator: unk intubation _____ extubation _____
++

Deceased: ☐ yes ☐ no Date of death _____
Cause of death _ unelated to tr _____

Remember to copy Orpheus ID to the top of this page.

Orpheus ID _____

TREATMENT (Not required to collect)

Was patient treated with drugs for this illness? ☐ yes (specify) ☐ no ☐ unk

Drug name	size/dose/frequency	start date	end date
_____		_____	_____
_____		_____	_____

Comments:

PROVIDERS, FACILITIES AND LABS

Reporter Type Pick one ☐ PMD ☐ MDX ☐ UC ☐ ER ☐ HCP

Reporter Name/Phone

_____

2nd Provider _____

Lab Fax/Phone_____

☐ Ok to contact patient (only list once)

EPI-LINKAGE

y	n	u	
☐	☐	☐	associated with known outbreak
☐	☐	☐	close contact of another case
			Nature of contact _ workplace
☐	☐	☐	has case been reported

Epi-link ☐ household ☐ sporadic ☐ cluster ☐ outbreak ☐ close contact

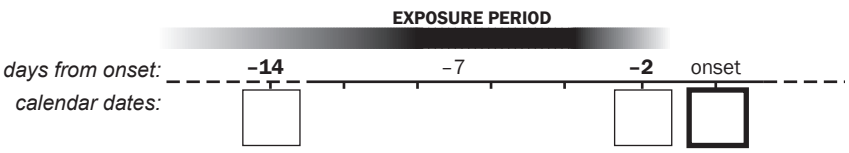
Outbreak ID_____

Exposure type ☐ single ☐ multiple ☐ unknown

Exposure date

INFECTION TIMELINE

Enter onset date in heavy box. Count back to figure the probable exposure period.



Symptom onset to 7 days post positive test or 72 hours symptom free, whichever is longer will also determine when PUI is off of home quarantine.

Interviewed ☐ yes ☐ no 1st call try _____ Date interviewed _____ Interviewed by _____

Person interviewed: ☐ patient ☐ provider ☐ parent ☐ spouse ☐ other _____

Reason not interviewed (choose one)

☐ not indicated ☐ unable to reach ☐ out of jursdiction ☐ deceased
☐ refused ☐ physician interview ☐ medical record review

Notes:

Remember to copy Orpheus ID to the top of this page.

Orpheus ID _____

POSSIBLE SOURCE(S) (RISKS) OF INFECTION DURING EXPOSURE PERIOD

Risks Provide ancillary details (names, locations, details) about possible sources and risk factors checked below as appropriate. Contact ACDP for details.

Y	N	R	U	**PRE-EXISTING MEDICAL CONDITIONS**
☐	☐	☐	☐	Chronic lung disease (asthma, emphysema, COPD)
☐	☐	☐	☐	Diabetes mellitus
☐	☐	☐	☐	Cardiovascular disease
☐	☐	☐	☐	Chronic renal disease
☐	☐	☐	☐	Chronic liver disease
☐	☐	☐	☐	Immunocompromised condition
☐	☐	☐	☐	Neurologic/neurodevelopmental/ intellectual disability (*if yes*,specify) _____
☐	☐	☐	☐	Other chronic diseases,(*if yes,* specify) _____
☐	☐	☐	☐	Current smoker
☐	☐	☐	☐	Former smoker
☐	☐	☐	☐	Obesity
☐	☐	☐	☐	Unknown
☐	☐	☐	☐	None

Notes

Y	N	R	U	**HOW IDENTIFIED**
☐	☐	☐	☐	Clinical evaluation
☐	☐	☐	☐	Contact tracing of case patient
☐	☐	☐	☐	Routine surveillance
☐	☐	☐	☐	Epi-x notification of travelers if yes, specify DGMQ ID _____
☐	☐	☐	☐	Unknown
☐	☐	☐	☐	Other _____

Y	N	R	U	**RISK QUESTIONS**
☐	☐	☐	☐	Any travel history outside their home area
☐	☐	☐	☐	Attend gatherings, excluding workplace in 14 days prior to illness onset or positive test (parties, mass gatherings sporting events, etc) Describe *date, location, size*
☐	☐	☐	☐	Live congregate setting (specify) LTC _____
☐	☐	☐	☐	Work congregate setting (specify) LTC
☐	☐	☐	☐	Close contact of confirmed case
☐	☐	☐	☐	HH contact with confirmed case
☐	☐	☐	☐	Community contact with confirmed case
☐	☐	☐	☐	Health care contact with confirmed case, if yes direct patient care (describe)_____
☐	☐	☐	☐	In the 14 days before symptom onset, did case attend or work in following settings, check all that apply: Daycare ☐ School ☐ Camp ☐ Sports practice/game ☐ Unk ☐ Other (specify name and location) ☐ _____
☐	☐	☐	☐	Use cannabis, THC, or CBD in what form, check all that apply ☐ vaping/cartridge/dabbing ☐ edible ☐ combustible ☐ other _____

Y	N	R	U	**TRAVEL**
☐	☐	☐	☐	History of travel outside home area if *yes,* provide information departure _____ return _____
☐	☐	☐	☐	Outside of U.S. to _____
☐	☐	☐	☐	Within Oregon to _____

Specify travel modes (i.e. car plane, cruise ship, etc_____
Specify companions (i.e. solo, same HH, multiple HH, organized tour, military) _____

Notes

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Orpheus ID ____________

FOLLOW-UP

Y N R U

☐ ☐ ☐ ☐ Case in public setting other

☐ ☐ ☐ ☐ Case know anyone with similar illness

if yes,describe relationship other

☐ ☐ ☐ ☐ Case recovered

if yes, date of last symptoms ______

☐ ☐ ☐ ☐ Exposures to vulnerable populations while ill

if yes,check all that apply

☐ Contact with vulnerable population

☐ Lives with a vulnerable population

☐ Other exposure to a vulnerable population

Y N R U

☐ ☐ ☐ ☐ Case interested in receiving information about becoming participant in COVID-related studies as OHA learns of them? If *yes*, specify best way to contact case

____

☐ ☐ ☐ ☐ Case need wrap-around services

Specify ______________________________ __

Notes

HOUSEHOLD CASE AND HIGH-RISK CONTACT MANAGEMENT AND FOLLOW-UP

HOUSEHOLD ROSTER (workplace and other contact/roster sheets at end of document)

Name	DoB or Age	Sex	Relation to case	Occupation	Educ provided	Phone number	Email	Last Exposure	Interview Date	Sick	High risk
		Ref	other		☐ Y ☐ N	______		______	______	☐ Y ☐ N	☐ Y ☐ N
		Ref	other		☐ Y ☐ N	______		______	______	☐ Y ☐ N	☐ Y ☐ N
		Ref	other		☐ Y ☐ N	______		______	______	☐ Y ☐ N	☐ Y ☐ N
		Ref	other		☐ Y ☐ N	______		______	______	☐ Y ☐ N	☐ Y ☐ N
		Ref	other		☐ Y ☐ N	______		______	______	☐ Y ☐ N	☐ Y ☐ N

Make additional copies of this sheet as needed.

Orpheus ID _____

Definition for close contact: Being within 6 feet of a COVID-19 case during their period of transmissibility for ≥15 minutes

EMPLOYMENT INFORMATION (ONLY IF CLIENT WAS SYMPTOMATIC WHILE AT WORK)

Name of workplace: _____

Address _____

Worked while sick ☐ Y ☐ N ☐ R ☐ U if worked while sick, indicate schedule_____

Last day woked _____

Transportation to work (carpool, transit Uber etc)_____ List ride-sharing people in work contacts.

If working in a Long-Term or Health Care Facility: Describe job details. *Work details if high risk setting/occupation: (get info on size of work area (close quarters, spread out, ventilation?) meetings since onset with others, include lunch room, break exposures, size of room, number of people etc.*)

Does case need a letter for work? ☐ Y ☐ N ☐ R ☐ U

WORK CONTACTS (BEING WITHIN 6 FEET FOR 15 MINUTES

Sick	Name	Sex	Phone Number	Email
☐ Y ☐ N ☐ R ☐ U		Ref		
☐ Y ☐ N ☐ R ☐ U		Ref		
☐ Y ☐ N ☐ R ☐ U		Ref		
☐ Y ☐ N ☐ R ☐ U		Ref		
☐ Y ☐ N ☐ R ☐ U		Ref		

SOCIAL CONTACTS / FREQUENT HOUSEHOLD VISITORS (BEING WITHIN 6 FEET FOR >15 MINUTES)

Sick	Name	Relationship	Date of Birth	Sex	Phone Number	Email
☐ Y ☐ N ☐ R ☐ U		other	_____	Ref		
☐ Y ☐ N ☐ R ☐ U		other	_____	Ref		
☐ Y ☐ N ☐ R ☐ U		other	_____	Ref		
☐ Y ☐ N ☐ R ☐ U		other	_____	Ref		
☐ Y ☐ N ☐ R ☐ U		other	_____	Ref		
☐ Y ☐ N ☐ R ☐ U		other	_____	Ref		

Local Epi _____

Date report received by LPHA _____

LPHA completion date _____

State completion date _____

Print Form Clear Form

Orpheus ID

RACE, ETHNICITY, LANGUAGE, AND DISABILITY (REALD)

RACE AND ETHNICITY

How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry?**

Specify _____

Which of the following best describes your **racial or ethnic identity?** *Check **all** that apply.*

Amer Indian/ Alaska Native
- ☒ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, First Nation
- ☐ Indigenous Mexican. Central American, South American

Hispanic or Latinx
- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Puerto Rican
- ☐ Other Hispanic or Latinx

Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☒ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

If you selected more than one racial or ethnic identity, circle the one that **best** represents your racial or ethnic identity. If you have **more than one** primary racial or ethnic identity please check here. ☐.

Native Hawaiian/ Pacific Islander
- ☐ Guamanian
- ☐ Chamorro
- ☐ Micronesian/Marshallese/Palaun (COFA)
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Black or African American
- ☒ African American
- ☐ African (Black)
- ☐ Caribbean (Black)
- ☐ Other Black

Middle Eastern Northern African
- ☐ Northern African
- ☐ Middle Eastern

White
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

Other Categories
- ☐ Other (please list) _____
- ☐ Don't know
- ☐ Don't want to answer

LANGUAGE

Do you speak a language other than English at home? If so
What language to speak at home?
In which language you feel most comfortable speaking with your doctor or nurse?
How well do you speak English? Very well
Do you need an interpreter for us to communicate with you? Yes
Are you deaf or do you have serious difficulty hearing? Yes

DISABILITY.

Your answers to the questions help us find health and service differences among people with disabilities or limitations. Your answers are confidential.

For all ages:

Are you blind or do you have serious difficulty seeing even when wearing glasses? No

Does a physical, mental or emotional condition limit your activities in any way? Yes

For ages 5 and up:

Do you have serious difficulty walking or climbing stairs? Declined
Do you have difficulty dressing or bathing? Declined
Because of a physical, mental, or emotional condition, do you have serious difficulty:
A. Concentrating or remembering or making decisions Declined

For ages 15 and up:

B. Doing errands alone such as visiting a doctor's office or shopping? Declined