REQUIRED fields are **bold font** and followed by an asterick symbol (*)

1234 2nd Ave S, Okanogan, WA 98840 *www.okanogancountycovid19.org* (509) 422-7140

Patient Name* _____
First Middle Last

If Patient is less than 18 years old, Parent's Name _____
First Last

Birth Date* _____ / _____ / _____ Age today_____ Gender ❑ Male ❑ Female

Phone number* (_____) _____ Msg phone (_____) _____

Primary Language ❑ English ❑ Spanish ❑ Other Interpreter needed? ❑ No ❑ Yes

Primary Care Provider* ***(PCP)*** _____ Location _____
Clinic name / City

Physical Address* _____

City* _____ **State*** _____ **Zip*** _____ **County*** _____

PO Box_____ City_____ State_____ Zip_____ County_____

WA state resident? ❑ No ❑ Yes How many other people do they live with? _____

❍ Congregate setting *(Long term care, Multi-generational household, Dormitory, etc)* ❍ Homeless ❍ H2A Visa

❍ Other residence type (Single Family, Apartment, etc) _____

Name of Employer / School* _____ Last date Attended _____

Employer / School Phone # _____ **Supervisor's / Teacher's Name*** _____

Positive COVID-19 test date: _____ Received COVID-19 vaccine? ❑ No ❑ Yes Booster? ❑ No ❑ Yes

Signs / Symptoms*

Date Symptoms Started: _____

Date Isolation Ended: _____

- ❍ **None**; *none of the symptoms listed below*
- ❍ Fever
- ❍ Chills
- ❍ Headache
- ❍ Muscle aches or pain
- ❍ Sore throat
- ❍ Congestion
- ❍ Cough
- ❍ Dyspnea (shortness of breath)
- ❍ Nausea
- ❍ Vomiting
- ❍ Diarrhea
- ❍ Abdominal pain or cramps
- ❍ New onset loss of taste / smell
- ❍ Fatigue
- ❍ Other symptoms consistent with this illness; Specify = _____

Recent exposure to a person confirmed to have the COVID-19 / SARS-CoV-2?

❑ No / Unknown ❑ Yes; Date_____

If Yes, please list name(s) below!

Name	*Relationship*
_____	_____
_____	_____
_____	_____

Pre-existing Health Conditions*

- ❑ Diabetes
- ❑ Heart disease
- ❑ Immunocompromised
- ❑ Obesity
- ❑ Respiratory conditions (COPD, asthma, etc)
- ❑ Smoker
- ❑ Pregnant
- ❑ Other; Please specify = _____

Authorization to Disclose COVID 19 Test Results to Second Party

Verbal permission given to share COVID-19 results with anyone who answers the call to any of the phone number(s) provided on this form. ❑ No ❑ Yes *Details, if any*: _____

*>>> Please **FAX to (509) 422-7152***

COVID-19 High Risk Case Report

Revised 03.08.22