



Outbreak #: (if known)

COVID-19 Symptomatic and Suspect Health Care Provider Reporting Form

Facility Name:	
Date:	Time:
HCW Last Name:	First Name:
D.O.B.:	Phone:
Symptoms	
Onset Date:	
New / Worsening:	
<input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath (dyspnea) <input type="checkbox"/> Sore throat <input type="checkbox"/> Runny nose <input type="checkbox"/> Sneezing <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Hoarse voice <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> New olfactory or taste disorder	<input type="checkbox"/> Nausea / vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Unexplained fatigue/malaise <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Other symptoms consistent with the most recent COVID-19 Reference Document for Symptoms: _____
Date last worked:	
<input type="checkbox"/> Health care worker advised to self-isolate and to tell close contacts to self-isolate <input type="checkbox"/> Health care worker added to facility line list	
Please indicate if the staff member:	
<input type="checkbox"/> Had testing completed at the facility, if so, please indicate the date the swab was collected: _____	
<input type="checkbox"/> Has been referred to RCVTAC to register for testing and has been given Outbreak # (staff need to be aware that Outbreak # MUST be added to their lab requisition when they are tested).	
Fax to Renfrew County and District Health Unit (RCDHU) at (613) 735 – 3067	
For questions call RCDHU Long-term Care Retirement Home line at (613) 602-6055 , between 8:00 am and 4:00 pm, daily.	