Clinical Update Form in Acute Care Settings - Hospitalized COVID-19 Case - Acute Care Facility Use

Please **FAX Daily** to **613-735-3067**
Tel: 613- 602-5963

Name of Facility: _____ Date: _____

Facility Contact:_____ Phone Number:_____ Fax #: _____

Please list each patient admitted to hospital who has tested positive for COVID-19

Case Last Name	Case First Name	Gender (M/F/Other)	Date of Birth (year/month/day)	Admission Date (year/month/day)	Admission Location (Unit)	Admission Diagnosis	ICU Level Care? (Y/N/DK)	Intubated or Ventilated? (Y/N/DK)	Is the client admitted to the hospital due to their COVID-19 infection? Is the client's symptoms or complications extending their hospital stay? If so, answer YES below. If their COVID-19 infection is unrelated to their hospital stay answer N/A	Discharge Date (year/month/day)	Is the client deceased? Y/N

Adapted from Recommendations for, "The Control of Respiratory Infection Outbreaks in Long-Term Care Homes, March 2018."
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