Name / Alias	Age/ DOB	Race/ Ethnicity	Gender	Contact Info (telephone numbers, addresses)	Date(s) of Exposure	Type of Exposure	Co-morbidities / Underlying Conditions	Recent Travel? Dates and locations	Symptoms	Is this contact a healthcare worker?	Risk Level (High, Medium, Low, None)	Referred for:	Date Tested and Location
						Household Community Healthcare			☐ Fever ☐ Cough ☐ Difficulty breathing ☐ Other:____	YES / NO		☐ Testing ☐ Medical Evaluation ☐ Other: ________	
						Household Community Healthcare			☐ Fever ☐ Cough ☐ Difficulty breathing ☐ Other:____	YES / NO		☐ Testing ☐ Medical Evaluation ☐ Other: ________	
						Household Community Healthcare			☐ Fever ☐ Cough ☐ Difficulty breathing ☐ Other:____	YES / NO		☐ Testing ☐ Medical Evaluation ☐ Other: ________	
						Household Community Healthcare			☐ Fever ☐ Cough ☐ Difficulty breathing ☐ Other:____	YES / NO		☐ Testing ☐ Medical Evaluation ☐ Other: ________	
						Household Community Healthcare			☐ Fever ☐ Cough ☐ Difficulty breathing ☐ Other:____	YES / NO		☐ Testing ☐ Medical Evaluation ☐ Other: ________	
						Household Community Healthcare			☐ Fever ☐ Cough ☐ Difficulty breathing ☐ Other:____	YES / NO		☐ Testing ☐ Medical Evaluation ☐ Other: ________	
						Household Community Healthcare			☐ Fever ☐ Cough ☐ Difficulty breathing Other:____	YES / NO		☐ Testing ☐ Medical ☐ Evaluation Other: ________	

COVID-19 Case Name: ______________________ COVID-19 Case DOB: __/__/__ COVID-19 Case ID#: ___________________ Date PUI Interviewed: ____________