

RESIDENT COVID 19 LIST

- A. Facility- this needs to be completed on all forms in all spaces indicated facility. (do not use "quotations ")
- B. County- this needs to be completed on all forms in all spaces indicated facility. (do not use "quotations ")
- C. Resident Last Name- Required
- D. Resident First Name – Required
- E. Unit- Required (hall they are on)
- F. Room Number- Required.
- G. Date DHHS notified- required (MM/DD/YY)
- H. Covid Tested- required (answers are YES or NO)
- I. Date tested- Required (if not tested leave blank)
- J. Positive- Required (answers are POSITIVE, NEGATIVE OR PENDING- If not tested leave blank)
- K. Death- YES if a death occurred- date will be placed in notes. Leave blank if no death.
- L. Presumed positive- Required (answers are YES and NO). Yes if the persons test is pending.
- M. Isolation required – (answers are YES and NO).
- N. Date isolated- required (MM/DD/YY)
- O. Isolation D/C required (MM/DD/YY)- of unknown _____????
- P. Onset date required (MM/DD/YY)
- Q. Precautions: required (what type of isolation being used)

If your sheet ends here it is not the current sheet.

- R. Resident DOB Required (MM/DD/YY)
- Race
- S. Please select one of the following:
- T. WHITE
- U. BLACK OR AFRICAN / AMERICAN
- V. AMERICAN INDIAN AND ALASKA NATIVE.
- W. ASIAN.
- X. NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER
- Z. Notes: this is where the date of death will be placed. (MM/DD/YY)
- y. TWO OR MORE RACES
- Z. NOTES: THIS IS WHERE YOU WILL PLACE NOTES SUCH AS: DATE OF DEATH, HOSPITALIZATION, ETC.