The purpose of this form is to provide critical information to health care and hospital workers for residents in supportive housing who need care during the COVID-19 pandemic. It is recommended to provide the resident with several copies to bring to the hospital so that staff there know critical information about the individual’s health and housing status.

**Date**: Click or tap to enter a date.

*Patient Information*

|  |  |
| --- | --- |
| **Last Name**: Click or tap here to enter text.  **First Name**: Click or tap here to enter text.  **Address**: Click or tap here to enter text. | **Date of Birth**: Click or tap to enter a date. |
| **Contact information for patient**:  Phone: Click or tap here to enter text.  **Contact information for patient next of kin**:  **Name**: Click or tap here to enter text.  **Phone**: Click or tap here to enter text. | **Contact information for patient’s case manager at**: Enter agency name  **Name**: Click or tap here to enter text.  **Email**: Click or tap here to enter text.  **Phone**: Click or tap here to enter text.  **Contact information for Primary Care Provider**  **Name:** Click or tap here to enter text.  **Phone:** Click or tap here to enter text. |

*Background Health Information that Contributes to Vulnerability to COVID-19 Complications*

|  |  |  |
| --- | --- | --- |
|  | Patient has a diagnosed chronic physical condition | **Explain**: |
|  | Patient has a diagnosed mental health condition | **Explain**: |
|  | Patient has a substance use disorder | **Explain**: |

*COVID-19 Symptoms*

|  |  |
| --- | --- |
| Patient has experienced symptoms typical of COVID-19: | Check if Yes |
| Fever. If Yes, last temp?: Click or tap here to enter text. |  |
| Dry cough |  |
| Shortness of breath |  |
| Tiredness |  |
| Date of first symptoms | Click or tap to enter a date. |

*COVID-19 Tests*

|  |  |
| --- | --- |
| Has the patient been tested for coronavirus? | Yes  No  Unknown  If Yes, where? Click or tap here to enter text.  Date of test? Click or tap to enter a date. |
| Test Results | Confirmed coronavirus  Unknown/inconclusive |
| Has the patient been in contact with COVID-positive individuals? | Confirmed  Unknown |

*Isolation/Quarantine*

|  |  |
| --- | --- |
| Does patient have a place to self-quarantine safely? | Yes  No |
| If patient has been in quarantine already, what is the start date? | Select date:  Click or tap to enter a date. |

*Other Notes (medications, etc.)*

|  |
| --- |
|  |