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.)*

|  |
| --- |
|  |