VENTURA COUNTY PUBLIC HEALTH

Ventura County Public Health
Communicable Disease Program
2220 E. Gonzales Rd., Suite 110
Oxnard, CA 93036
Phone 805-981-5201, Fax 805-981-5200
Email: vcph-id@ventura.org

Notification From Medical Provider of COVID-19 Laboratory Results

MEDICAL PROVIDER INFORMATION

Physician/Infection Preventionist Name	Facility Name	
Physician/ Infection Preventionist Pager/Phone number	E-mail Address	Date of Report

PATIENT INFORMATION

Patient Name-Last, First, Middle Initial	Facility name (if not living at home):	Date of Birth	Age	Sex
Address- Number, Street, Apt #	City	State	ZIP Code	
Primary Phone Number	Alternative Phone Number	Email Address		

Patient currently resides in: ☐ Private residence ☐ Hotel ☐ Homeless ☐ Detention facility ☐ Nursing home/long-term healthcare
☐ Residential Care/Assisted Living ☐ School/University dorm ☐ Military base ☐ Shelter ☐ Other: _____

Occupation: ☐ Healthcare Worker ☐ Teacher ☐ EMT ☐ Other: _____
Ethnicity: Select _____ Race: Select _____

CLINICAL INFORMATION

Date of onset	Hospitalized? ☐ Yes ☐ No	Date of admission	Medical Record Number

Does the patient have the following signs and symptoms (check all that apply)? ☐ Loss of smell or taste

☐ None ☐ Muscle aches ☐ Sore throat ☐ Subjective Fever ☐ Abdominal pain
☐ Cough ☐ Diarrhea ☐ Chills ☐ Runny nose ☐ Other, Specify:_____
☐ Shortness of breath ☐ Fever (>100.4F or 38C) ☐ Vomiting or nausea ☐ Headache ☐ Unknown

Severe Acute Lower Respiratory Illness: (☐ pneumonia **OR** ☐ ARDS): Chest x-ray/CT results: _____

Pre-existing medical conditions (check all that apply):

☐ None ☐ Unknown ☐ Pregnancy ☐ Diabetes ☐ Hypertension ☐ Cardiovascular disease ☐ Chronic pulmonary disease
☐ Asthma ☐ Chronic renal disease ☐ Chronic liver disease ☐ Immunocompromised ☐ Neurologic disability
☐ Other:_____

LABORATORY INFORMATION

Nasal pharyngeal swab:	Date of Collection: _____	Result: _____	Performing lab name: _____
Oropharyngeal swab:	Date of Collection: _____	Result: _____	Performing lab name: _____
Sputum:	Date of Collection: _____	Result: _____	Performing lab name: _____
Endotrachial:	Date of Collection: _____	Result: _____	Performing lab name: _____

EPIDEMIOLOGY RISK FACTORS

☐ Close contact with a laboratory-confirmed COVID-19 patient

Explain: _____

☐ Travel history to affected geographic areas: (City/Region/Province/State/Country): _____

See current list: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html

Dates of Travel: To:_____ From:_____ Arrived in U.S.: _____

☐ No known identifiable source

SEND COMPLETED FORM TO THE COMMUNICABLE DISEASE PROGRAM BY FAX at (805) 981-5200 or SECURE EMAIL TO: vcph-id@ventura.org