NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs *for all*
Department of Health and Human Services

New Hampshire Confidential COVID-19 Case Report Form

For Reporting Suspect and Confirmed Cases

v 6/2023

☐ Hospitalization ☐ Death ☐ Multisystem Inflammatory Syndrome(MIS) Report Date: ____/_____/_____

Patient Information

Name (Last)_____(First)_____(M.I.)_____

Date of Birth _____/_____/_____ Sex: ☐ Male ☐ Female ☐ Intersex ☐ Choose not to disclose

Gender Identity: ☐ Female ☐ Male ☐ Transgender Woman/ Female ☐ Transgender Man/ Male

☐ Other gender, please specify _____ ☐ Choose not to disclose

Pregnant: ☐ Yes ☐ No ☐ Unk If yes, estimated date of delivery: _____/_____/_____

Address: _____City/Town _____ State _____ Zip _____

Phone: Cell_____ Home _____ Work _____

Race: ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ Native Am./Alaskan Nat ☐ Unknown ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Occupation/Employment (select all that apply): ☐ Healthcare ☐ Educator ☐ Childcare ☐ Student ☐ Other: _____

Employer/Institution (name and City/ State): _____

Staff or Resident of: ☐ Long-term care facility ☐ Educational dormitory/housing ☐ Other residential setting_____

Test Results

Test Results: ☐ Positive/detected ☐ Negative/not detected ☐ Indeterminate/Inconclusive Collection Date:____/_____/_____

Test Type: ☐ NAAT/PCR ☐ Antigen ☐ Antibody Specimen Source: ☐ NP ☐ Nasal ☐ OP ☐ Saliva ☐ Blood

Symptoms and Clinical Information

Symptomatic? ☐ Yes ☐ No ☐ Unknown If yes, onset: ____/_____/_____

☐ Abdominal pain	☐ Chest congestion	☐ Chest pain	☐ Chills	☐ Cough	☐ Diarrhea
☐ Fatigue	☐ Fever	☐ Headache	☐ Loss of smell	☐ Loss of taste	☐ Muscle aches
☐ Sinus congestion	☐ Nausea	☐ Runny nose	☐ Shortness of breath	☐ Sore Throat	☐ Other_____

Hospitalized due to Covid? ☐ Yes ☐ No ☐ Unk

Hospital Location:_____ Dates: ____/_____/_____ - ____/_____/_____

In ICU? ☐ Yes ☐ No ☐ Unk Mechanical Ventilation? ☐ Yes ☐ No ☐ Unk

Patient Die? ☐ Yes ☐ No ☐ Unk Date of Death:_____/_____/_____ Location: _____

COVID-19 Contributing Cause of Death? ☐ Yes ☐ No ☐ Unknown

Health Care Provider Reporting Information

Person Reporting: _____ Provider _____ Phone _____

Provider Facility/Practice/Lab Name _____City/Town_____ State_____

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