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 v 4/08/2021

For Reporting Suspect and Confirmed Cases

☐ New diagnosis **OR** ☐ hospitalization or death of previously confirmed patient 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? ☐ 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

Vaccinated for COVID-19: ☐ Yes ☐ No ☐ Unk

First Dose ☐ J&J Janssen ☐ Moderna ☐ Pfizer-BioNTech ☐ Other_____ Date____/_____/_____

Second Dose ☐ Not required ☐ Moderna ☐ Pfizer-BioNTech ☐ Other_____ Date____/_____/_____

Risk Factors/Reason for Testing (check all that apply within the 14 days prior to diagnosis or specimen collection if asymptomatic)

International/Domestic Travel: ☐ Yes ☐ No ☐ Not asked ☐ Unknown Details:_____

Contact to a case: ☐ Yes ☐ No ☐ Not asked ☐ Unknown Details: _____

No known risk factors: ☐ Yes ☐ No ☐ Not asked ☐ Unknown

Additional Details(e.g., including names, relationship of contact and venue):_____

Health Care Provider Reporting Information

Person Reporting: _____ Provider _____ Phone _____

Provider Facility/Practice/Lab Name _____City/Town_____ State_____