Cuyahoga County Board of Health COVID-19 Tracking Form v.4 [4/23/2020]

Cluster ID:

Name:	DOB:						
Gender: M F I	Non-binary Unknown						
If minor, parent/gu	uardian(s) name:						
Address:							
City:		Zip code:					
Phone:	Text OK: Y N						
Phone:	Text OK: Y N	Email:					
Informant Informa	ation (if not patient)						
Informant 1:							
	Phone: Additional Information:						
Informant 2:							
Phone:	Additional Information	tion:					
	,						
ISOLATION Isolation until d/c criteria met (check CDC guidance)	□ Lab confirmed positive □ Date: ○ ODRS # □ Probable Positive Symptom Onset Date: ○ ODRS # Related Case Name: Related Case ODRS # (if applicable)	Letter/packet Date sent: Initials: D/C Isolation Date: Letter					
QUARANTINE 14 days from last contact or entry to country without symptoms Start: End:	☐ Traveler Return date: ☐ Case contact (confirmed/presumptive) Exposure date: Case Name: Related Case ODRS # (if applicable	- Initials:					

	Healthcare worker		Pregnant			
	Facility		Delivery Ho	ospital		
	Date last worked		Due Date			
	Facility notified? y / n / unknown		Actual Deliv	very Date		
			Breastfeed	ing?y/n/unknown		
	Institutionalized					
	Facility type: LTC SNF Group home	Cor	rectional	Other		
	Facility name:			_		
Special concerns (e.g. Resource needs identified, facility where hospitalized if applicable)						

Response Team

Name	Credentials	Signature	Initials