CUYAHOGA COUNTY
BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

COVID-19 Isolation Discontinuation Form

1. Name: _____ _____ _____ DOB: _____
   First Name *Middle Initial* *Last Name*

2. Mailing Address: _____
   Mailing Address

   Phone #: _____ E-mail address:_____

3. Interviewer has verified race and ethnicity were completed on PUI form. If NOT please complete:

   Race (check all that apply)**:**

   ☐ Asian ☐ American Indian/Alaska Native
   ☐ Black ☐ Native Hawaiian/Other Pacific Islander
   ☐ White ☐ Unknown

   Ethnicity:

   ☐ Hispanic/Latino
   ☐ Non-Hispanic/Latino
   ☐ Not Specified

4. **Sex:** ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Say

5. Is the patient a health care worker or first responder? ☐Yes ☐No If **Yes** please specify: _____

6. COVID-19 case type:

   ☐ Lab Confirmed ODRS# _____ Date of Collection _____

   ☐ Presumptive positive (Probable)

   Date of symptom onset _____Date of significant symptom resolution _____

7. Was the patient hospitalized during their illness? ☐ Yes ☐ No

   Admission Date: _____ Discharge Date: _____

   If **YES** did the patient require (check all that apply) ☐ICU stay ☐ ventilator ☐ ECMO ☐ Deceased

8. Did the individual undergo testing for COVID more than one time? ☐ Yes ☐ No

   If **YES** indicate dates and results if available Date:_____Result:_____
   Date:_____Result:_____
   Date:_____Result:_____

9. Date of Initial COVID-19 Interview _____

   Any new symptoms following the initial COVID-19 interview ☐ Yes ☐ No

   If **YES** briefly describe additional symptoms and onset: _____

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10. Did the patient have any of the following symptoms in the past 72 hours? Patient has been asymptomatic ☐

Fever/ Subjective fever	☐ No	☐ Yes		Shortness of Breath	☐ No	☐ Yes
Cough	☐ No	☐ Yes		Myalgias	☐ No	☐ Yes
Chills	☐ No	☐ Yes		Nausea/ vomiting	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes		Abdominal Pain	☐ No	☐ Yes
Congestion/ Rhinorrhea	☐ No	☐ Yes		Diarrhea	☐ No	☐ Yes
Sore throat	☐ No	☐ Yes		Back Pain*	☐ No	☐ Yes
Loss of taste/smell	☐ No	☐ Yes		Headache*	☐ No	☐ Yes
Other (specify):				Other (specify):		

*should be different from baseline

11. Criteria used for isolation discontinuation (check one)

☐ Test based strategy Collection date(s) _____ Test Results ☐ Negative ☐ Positive

☐ 72 hours since symptom recovery* AND at least 10 days since symptom onset strategy

☐ For Asymptomatic – 10 days from the date of testing

☐ 72 hours since symptom recovery* AND at least 14 days since symptom onset strategy (for individuals in congregate settings)

☐ For asymptomatic in congregates settings – 14 days from the date of testing

* resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (E.G. cough, shortness of breath)

12. Are the patient's respiratory symptoms currently at baseline? ☐ Yes ☐ No

If **NO** explain why _____

13. Based on your judgement is the patient cleared from isolation? ☐ Yes ☐ No

Is the patient interested in being contacted for additional data collection or clinical trial testing?
☐ Yes ☐ No

If **YES** Preferred method of communication ☐ Telephone ☐ Text ☐ E-mail

14. Does the patient have a PCP? ☐ Yes ☐ No

IF yes, please specify _____

Person completing evaluation form _____ Date of isolation discontinuation _____