# HMIS Data Collection for COVID-19 Sub-Assessment *- [ALL CLIENTS] - [ALL PROJECTS]*

**This form is for all project types. There may be multiple Record Dates over time; use a new form for a new Record Date.**

**RECORD DATE (Month / Day / Year):**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | / |  |  | / |  |  |  |  |

# Section I: Client has symptoms of Covid-19

**DATE SYMPTOMS STARTED? (Month / Day / Year):**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | / |  |  | / |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **FEVER?** | **COUGH?** | **SHORTNESS OF BREATH?** | **CHILLS?** | **MUSCLE PAIN?** | **HEADACHE?** | **SORE THROAT?** | **NEW LOSS OF TASTE OR SMELL?** |
|

|  |  |
| --- | --- |
|  | No |
|  | Yes |

 |

|  |  |
| --- | --- |
|  | No |
|  | Yes |

 |

|  |  |
| --- | --- |
|  | No |
|  | Yes |

 |

|  |  |
| --- | --- |
|  | No |
|  | Yes |

 |

|  |  |
| --- | --- |
|  | No |
|  | Yes |

 |

|  |  |
| --- | --- |
|  | No |
|  | Yes |

 |

|  |  |
| --- | --- |
|  | No |
|  | Yes |

 |

|  |  |
| --- | --- |
|  | No |
|  | Yes |

 |

**IF QUARANTINED OR SELF-QUARANTINED, DATE BEGAN? (Month / Day / Year):**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | / |  |  | / |  |  |  |  |

**IF HOSPITALIZED, DATE? (Month / Day / Year):**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | / |  |  | / |  |  |  |  |

**CLIENT HEALTH NOTES:**

|  |
| --- |
|  |

# Section II: Official COVID-19 Test Information

**DATE TESTED FOR COVID-19 (Month / Day / Year):**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | / |  |  | / |  |  |  |  |

|  |
| --- |
| **TYPE OF COVID-19 TEST?** |
|

|  |  |
| --- | --- |
|  | Viral Test – indicating current infection status |
|  | Antibody Test – indicating  |
|  | Unknown  |

 |

|  |
| --- |
| **IF KNOWN, TEST RESULT/CONFIRMED DISEASE STATUS?** |
|

|  |  |
| --- | --- |
|  | Viral Test – Positive: Confirmed to have COVID-19 |
|  | Viral Test – Negative: Confirmed to NOT have COVID-19 |
|  | Antibody Test – Positive: Confirmed to have COVID-19 antibodies |
|  | Antibody Test – Negative: Confirmed to NOT have COVID-19 antibodies |

 |

**DATE OF COVID-19 DIAGNOSIS? (Month / Day / Year):**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | / |  |  | / |  |  |  |  |

**NAME OF HEALTH PROVIDER PROVIDING DIAGNOSIS:**

|  |
| --- |
|  |

# Section III: Contact Information

**EMERGENCY CONTACT: FULL NAME & RELATIONSHIP**

|  |
| --- |
|  |

**EMERGENCY CONTACT: CONTACT INFORMATION**

|  |
| --- |
|  |

**\*\*COMPLTE WHEN A CLIENT NO LONGER HAS SYMPTOMS\*\***

**RECOVERY DATE:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | / |  |  | / |  |  |  |  |