# 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):**

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# Section I: Client has symptoms of Covid-19

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

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| **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):**

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

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**CLIENT HEALTH NOTES:**

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# Section II: Official COVID-19 Test Information

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

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| **TYPE OF COVID-19 TEST?** |
| |  |  | | --- | --- | |  | Viral Test – indicating current infection status | |  | Antibody Test – indicating | |  | Unknown | |

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| **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):**

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**NAME OF HEALTH PROVIDER PROVIDING DIAGNOSIS:**

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# Section III: Contact Information

**EMERGENCY CONTACT: FULL NAME & RELATIONSHIP**

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**EMERGENCY CONTACT: CONTACT INFORMATION**

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

**RECOVERY DATE:**

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