FAX to Spokane Regional Health District Epidemiology 509-324-3623

Clear Form

COVID-19 CASE REPORTING FORM

Section 1: PATIENT DEMOGRAPHICS REQUIRED

FIRST NAME:	LAST NAME:	Date of birth:
Patient address:		Sex at birth: ☐ Female ☐ Male

City	State WA	Zip	PHONE:

RACE: ☐ Asian ☐ Black ☐ American Indian/Alaska Native ☐ White ☐ Native Hawaiian/Other Pac Islander ☐ Unknown

ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Section 2: PATIENT VACCINATION INFO & BREAKTHROUGH CASE REPORTING

Is patient fully vaccinated? ☐ **YES** – continue next question below ☐ **NO** – please skip to Section 3

Is patient's vaccination in the WA IIS? (i.e., were they vaccinated at a clinic/pharmacy in WA State?)

☐ **YES** - please skip to Section 3 (patient's vaccination/breakthrough status has been reported automatically)

☐ **NO** or unknown - please complete Breakthrough Criteria and remainder of Vaccination Section

DOES CASE MEET ALL BREAKTHROUGH REPORTING CRITERIA LISTED BELOW?

☐ **YES** (complete remaining vaccination questions)

☐ **NO** (skip to Section 3)

- SPOKANE COUNTY RESIDENT
- FULLY VACCINATED AGAINST COVID-19
- POSITIVE PCR OR ANTIGEN TEST RESULT
- COLLECTION DATE IS ≥ 14 DAYS AFTER FINAL VACCINE DOSE
- PATIENT'S VACCINATION RECORD IS **NOT** IN WA IIS (i.e., vaccinated out of state or by a federal agency that does not report to WA IIS)

PLEASE RETAIN PCR SPECIMENS FROM PATIENTS WHO MEET BREAKTHROUGH CRITERIA with CYCLE THRESHOLD <30 FOR POSSIBLE FURTHER TESTING.

☐ **Moderna** ☐ **Pfizer** ☐ **Johnson & Johnson**

Dose #1 Date:	Dose #2 Date:
Lot#:	Lot#:
Where Given:	Where Given:

Please attach a copy of vaccination card or other official documentation if possible

Section 3: Reporting Facility Contact Information REQUIRED

Reporting facility name:	
Contact person at facility:	Phone number:

Section 4: Testing Information REQUIRED

Commercial Lab:

☐ LabCorp ☐ Incyte ☐ Quest

☐ Other lab (please specify):

PCR/MOLECULAR Point-of-Care Test:

☐ Abbot IDNow ☐ Roche cobas Liat

ANTIGEN Point-of-Care Test:

☐ Abbott BinaxNOW

☐ BD Veritor for Rapid Detection of SARS-CoV-2

☐ LumiraDx SARS-CoV-2 Ag Test

☐ Quidel Sofia 2 SARS Antigen FIA

Specimen Type:	Specimen collection date:	Reason for Testing *(Check all that apply)*:
☐ Nasal swab ☐ NP (nasopharyngeal swab)		☐ Symptomatic ☐ Known exposure ☐ Part of outbreak (specify in Notes section) ☐ Travel ☐ Other (specify in Notes section)

Section 5: Notes About This Case *(healthcare worker, LTC, school/childcare, etc.)*