

Registry Reporting



Initial Intake

Demographics:

Date: _____

County of Residence _____

Patient Name: _____

Patient Date of Birth: _____

Age _____

Sex Male Female

Race American Indian Alaskan Native
 Asian Black or African American
 Pacific Islander White

Pregnant Yes No

Admission/Encounter (date) _____

Admitted Yes No

Hospital/Facility Name _____

Discharge (date) _____

Site/mode of Presentation Clinic ER Video Visit

COVID-19 Testing:

Date of COVID-19 Positive Test _____ PUI

Testing Lab _____

Medical History/Exposures (Y/N):

Lung Disease

Asthma

COPD

Other Lung Disease _____

CV Disease

Heart Failure

Hyperlipidemia

Hypertension

Coronary Artery Disease

Other Heart Disease _____

Diabetes PreDiabetes Type1 Type2

BMI _____

Smoking Status

Current Smoker

Former Smoker

Vaping

Immunosuppression Yes No

Other Chronic disease (specify) _____

Initial Clinical Presentation Data:

Days of Symptoms prior to clinical presentation _____

Symptoms on clinical presentation

Fever Chills

Shortness of Breath Sore Throat

Cough Other _____

Weekly Follow up

Date: _____

Patient Name: _____

Patient Date of Birth: _____

Admission/Encounter (date) _____

Admitted Yes No

Hospital/Facility Name _____

Discharge (date) _____

COVID-19 Testing:

Date of COVID-19 Positive Test _____ PUI
Testing Lab _____

Treatments:

Pharmacologic Treatment

Hydroxychloroquine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Antiviral (Remdesivir, Lopinavir/ritonavir, etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Immune Modulator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Convalescent Plasma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Therapeutic Anticoagulant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Antibacterial	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Steroids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Rx Agent (Specify)	_____	

Therapies

Supplemental Oxygen	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Flow O2	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ventilation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other non-Rx Agent (Specify)	_____	

Outcomes:

Disposition _____

Death Yes No

Date of Death _____