patient education genius

User Guide
Covid19 Patient Form
April, 2021

You are being asked to complete a patient health form due to your recent lab results. The information that you provide is confidential and will not be shared with anyone outside of the health department. The answers you provide help us to keep our community safe and gather statistical data. You will not be identified in any data nor will anyone outside the health department know of your exposure.

Hello . This message is being sent as you have recently tested positive for COVID-19 or you were identified as a possible case because of a COVID-19 exposure. After you validate your birthdate we ask that you complete and submit the following form. If you have any questions please call the health department at 616-632-7266. Thank you for your participation.

Verify Last Name *

Verify Birth Month *

Verify Birth Date *

Authentication: Please provide your last name as well as your birth month and birthday. This information will be used to ensure the appropriate person is accessing the patient health form.

COVID-19 Patient Form

Thank you for verifying your date of birth. This message is being sent as you have recently tested positive for COVID-19 or you were identified as a possible case because of a COVID-19 exposure. The following form takes about 10-20 minutes and must be filled out in one sitting. Please click SUBMIT when finished. The information you provide contributes to a better understanding of the disease and how we can stop the spread.

To protect the health of others, isolate yourself from other people until 10 days after your illness started (or 10 days after your positive test if you don't have symptoms). Please tell people you have been around since 2 days before your illness started (or 2 days before your positive test if you don't have symptoms) to stay away from others for 14 days after the last time they had exposure to you.

Contact a healthcare provider if you have any questions or concerns about your health. If you need help answering the form or have other questions, please call us at 616-632-7266 at Kent County Health Department. We are committed to the health, wellness, and safety of you and your surrounding community. Sincerely Adam London, RS, MPA

Are you filling out this form on your behalf or on the behalf of a patient? *

- ○ Self
- ○ Someone else

Basic Information: When the patient form opens after authentication you may read information regarding how long the form takes to complete as well as contact information for your local health department. Please remember that someone from the health department will contact you if you choose not to complete the form.

Are you filling out this form on your behalf or on the behalf of a patient? *

- Self
- Someone else

Patient Name: *

First Name | Middle Name | Last Name

Patient current address: *

Street Address

City | Please Select State

Zip Code

Patient County *

Patient mobile number OR parent guardian mobile phone number (if a minor):

Completing the Form: All fields with a red asterisk * are required to be completed in order to submit the form. Please provide as much information as you can about yourself and your exposure. If you are completing the form for another individual, such as a minor or someone unable to complete the form on their own, you may indicate that on the very first question.

Hospitalization

Were you (patient) hospitalized?

- Yes
- No
- Unknown

Are you (patient) still hospitalized?

- Yes
- No

Hospital Name:

City:

Admission Date:

mm-dd-yyyy

Date

Hospitalization: If you choose "yes" to answer this question you will be presented with additional questions. Please complete to the best of your ability.

Did you (patient) experience any of the following? (Please check all that apply):

	Yes	No	Unknown
Fever (felt warm or measured fever)	○	○	○
Chills	○	○	○
Rigors (chills with shaking)	○	○	○
Muscle aches	○	○	○
Runny nose	○	○	○
Sore throat	○	○	○
Cough (new or worsening of chronic)	○	○	○
Shortness of breath	○	○	○
Nausea	○	○	○
Vomiting	○	○	○
Headaches	○	○	○
Stomach pain	○	○	○
Diarrhea	○	○	○
Tired/weak	○	○	○
Congestion	○	○	○
Wheezing	○	○	○
Difficulty breathing	○	○	○
Chest pain	○	○	○
Loss of taste	○	○	○
Loss of smell	○	○	○
Diagnosis of Pneumonia	○	○	○

Symptoms: Please click "yes" for any and all symptoms that you experienced during your illness. There is no need to click "no" or "unsure" unless you'd like to. Please list any symptoms that you experienced that are not included in the open text box.

Other symptoms (please list):

Please select all of the pre-existing or chronic conditions that apply:

	Yes	No	Unknown
Asthma/reactive airway disease	○	○	○
Autoimmune condition	○	○	○
Cancer	○	○	○
Cardiovascular disease	○	○	○
Chronic liver disease	○	○	○
Chronic renal disease	○	○	○
Chronic lung disease/COPD/emphysema	○	○	○
Diabetes mellitus	○	○	○
Hypertension	○	○	○
Neurologic disease	○	○	○
Severe obesity (BMI >=40)	○	○	○
Other chronic disease (Please specify below)	◉	○	○
Other immunosuppressive condition (Please specify below)	○	○	○
Psychological/psychiatric condition (Please specify below)	○	○	○
Disability (neurologic, neurodevelopmental, intellectual, physical, vision, or hearing impairment) (Please specify below)	○	○	○

Please specify other chronic disease(s):

Pre-Existing Conditions: Please click "yes" for any pre-existing conditions that you have. Some of the conditions, if "yes" is selected, will provide an open text box for you to list other conditions.

Are you (patient) a first responder (e.g. police, paramedic)?

- ○ Yes
- ○ No
- ○ Unknown

Are you (patient) a health care worker in the United States?

- ◉ Yes
- ○ No
- ○ Unknown

Health care facility name:

Type of healthcare worker:

Healthcare worker job setting:

Healthcare Worker Employer's address:

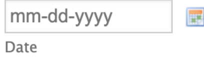
Street Address

High Risk Employee/Residence: If you live or work in a high risk setting, there are four areas that you can choose to best describe where you work/live. After you click "yes" you will be presented with fields to enter the Name of the Workplace/Living Facility as well as address. Please complete these fields if they apply to you.

Exposure Information

Exposure Information: Please give your best answer to these questions.

Date of 14 days prior to onset (or positive test date):



Date

Date you (patient) started isolating from others:

Date

Your (patient) occupation/job (or grade if a student):

Name of your (patient) workplace or school

Address of your (patient) workplace or school

Street Address

Work/School Information:
Please provide the name and address of your workplace and/or school. By providing this information, along with the last date you attended in person, we are able to determine if we need to contact anyone else relative to exposure.

Do you (patient) have any idea how you were exposed to COVID-19 (mark 'Yes' for all that apply)?

	Yes	No	Unknown
From a household member	○	○	○
From a known person with COVID-19 outside my household	○	○	○
In a healthcare setting	○	○	○
From a known COVID-19 cluster or outbreak 	○	○	○
Unknown/unsure	○	○	○

Do you know how you were exposed? Please indicate how you may have been exposed, Additional information may be included in the text box.

If you marked yes for any of the above, please provide further information about how you were possibly exposed to COVID-19 (including the name of the person you were exposed to):

Type here...

Last date in person at workplace or school

Date

In the 14 days prior to getting sick (or date of positive test result) until the date of isolation, did you (patient) visit or attend any of the following? Check all that apply.

	Yes	No	Unknown
Long term care/Skilled nursing facility assisted living/adult day care/group home	○	○	○
Jail/Prison/Detention Center	○	○	○
Shelters/settings that provide services for people experiencing homelessness	○	○	○
Healthcare (e.g. inpatient, outpatient, dental practices, dialysis, etc.)	○	○	○
Primary or secondary school/College or University outside of home (e.g. classroom, dorms, boarding schools, before/after school program, etc)	○	○	○
Childcare/Youth program (e.g. daycares, day/overnight camps, extra curricular activities, sports programs, etc.)	○	○	○
Agriculture/food processing/migrant camp (e.g. farm, meat packing, hatchery, etc.)	○	○	○
Workplace outside of home (e.g. manufacturing, construction, office building, etc.)	○	○	○
Shared transportation (airline, train, bus, etc)	○	○	○
Restaurant/bar	○	○	○
Social gathering (e.g. birthday party, graduation party, wedding, funeral, etc.)	○	○	○
Community event/mass gathering (e.g. concerts, rally, protests, parade, etc.)	○	○	○
Sporting event or practice (as a participant or spectator)	○	○	○
Gym or exercise class	○	○	○
Grocery store or retail	○	○	○
Other community exposure (e.g. nail/hair salon, spa, public beach/pool, etc.)	○	○	○
Exposure to animal with confirmed or suspected COVID-19	○	○	○
Other (may include previous listed categories if more than three unique places were visited)	○	○	○
Travel to a non-U.S. country	○	○	○
Travel to states and U.S. cities outside of Michigan	○	○	○
Travel within Michigan	○	○	○
Travel on cruise ship or vessel as passenger or crew member	○	○	○
Travel via airport/airline	○	○	○

Places you have been in the 14 days prior to illness prior to isolation. Please indicate anywhere that you visited in the 14 days prior to isolation. After selecting a place, you will be prompted to provide more details. This is very important to help stop the spread of this disease.

Gym or exercise class	○	○	○
Grocery store or retail	◉	○	○
Other community exposure (e.g. nail/hair salon, spa, public beach/pool, etc.)	○	○	○
Exposure to animal with confirmed or suspected COVID-19	○	○	○
Other (may include previous listed categories if more than three unique places were visited)	○	○	○
Travel to a non-U.S. country	○	○	○
Travel to states and U.S. cities outside of Michigan	○	○	○
Travel within Michigan	○	○	○
Travel on cruise ship or vessel as passenger or crew member	○	○	○
Travel via airport/airline	○	○	○

More information: Grocery store or retail *

Name(s)	Location(s)	Date(s) attended	Notes

+ Add Location

Starting 48 hours prior to your (patient) symptom(s) or the date of the positive test (if you (patient) didn't have symptoms) did you (patient) have close contact with anyone? (NOTE: close contact means being within 6 feet of someone for 15 minutes or longer or having physical contact) *

◉ Yes

○ No

Contact Information (Please click "Add Contact"):

First name of contact *	Middle name of contact	Last name of contact *	Contact Relationship *	Contact Phone #
			Please Select	
			Please Select	

+ Add Contact

Close Contacts:

It is critical that we contact anyone you may have been in close contact with to ensure they do not have symptoms of Covid-19, as well as to provide assistance and resources they may need while in quarantine. Close contacts include any household members, coworkers, or friends and family with whom you were within 6 feet of for a duration of 15 minutes or more (within a 24 hour period) starting from two days prior to experiencing symptoms (or testing positive with no symptoms), with or without a mask. Is there anyone that fits that description? You will need to scroll to the right to complete all fields. You may add up to 50 contacts here.

COVID-19 Vaccine History

Did you (patient) receive a COVID-19 vaccine?

- (•) Yes
- ( ) No
- ( ) Unknown

Number of vaccination doses given to patient prior to illness onset:

Vaccine History: Please have your Covid19 Vaccination Card available to complete the questions.

Vaccine #1 Type:

- ( ) Pfizer
- ( ) Moderna
- ( ) Johnson & Johnson (Janssen)
- ( ) AstraZeneca
- ( ) Unspecified
- ( ) Other
- ( ) Unknown

Administered Date #1:

mm-dd-yyyy

Date

Dose Number #1:

Lot Number #1:

Manufacturer #1:

Is case requesting a return to work letter?

- ( ) Yes
- ( ) No
- ( ) Unknown

Return to Work Letter: Please choose "yes" if you are requesting a return to work letter. Someone with the health department will contact you to supply you with this document.

Submit

Submit: Please click the "submit" button at the end of the patient form. This will save your answers. You will receive a Thank You message with education links to help you manage your illness. Thank you for helping us to protect the citizens of our community!