COVID-19 Reporting Form
Providers Serving Westchester County Residents
Westchester County Department of Health
**FAX to 914-813-5182**

---

Patient Name: _____ DOB: _____

Address: _____

Municipality of Residence: _____ Zip Code: _____

Cell Phone: _____ Home Telephone: _____

Email address: _____

Gender: ◯ Male ◯ Female Ethnicity: ◯ Hispanic ◯ Non-Hispanic ◯ Unknown

Race: ◯ White ◯ Black ◯ Asian ◯ Native American/Alaskan

◯ Pacific Islander/Native Hawaiian ◯ Other ◯ Unknown

Is the patient a student or staff of any **school** or **college** OR is the patient a **staff or resident of a congregate living facility** (e.g. nursing home, assisted living facility, group home, shelter, correctional facility, residential children's facility)? ☐ YES ☐ NO

If YES, please provide School or Facility information:

Name _____ Telephone: _____

Address_____ Zip Code_____

---

☐ Symptomatic/Onset Date _____ ☐ Asymptomatic

**Specimen Collection Date: _____ COVID POC Test Kit Manufacturer _____**

**POC Test Type: ☐ Antigen ☐ ID NOW (Molecular) ☐ Cepheid XPert Xpress (Molecular)**

## PLEASE ATTACH COVID-19 POSITIVE (+) LAB REPORT

---

_____
[Ordering/Treatment Provider Signature] [Ordering/Treatment Provider Print Name]

Date:_____ Telephone:_____ Fax: _____

Additional Comments:

Clear Form

Revised: 11/12/20