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:_____

Home Telephone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email address: _____

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

Race: ◯ White ◯ Black ◯ Asian ◯ Native American/Alaskan
◯ Pacific Islander/Native Hawaiian ◯ Other ◉ Unknown

Is patient a staff or resident of a congregate living facility (nursing home, assisted living facility, group home, shelter, correctional facility, residential children's facility, residential school or college)?

◯ YES ◯ NO

If YES, please provide Facility:

Name _____ Telephone (_____) _____-_____

Address_____ ZIP Code_____

Date of Diagnosis: PLEASE PROVIDE COVID-19 POSITIVE (+) LAB REPORT
The Lab Report MUST SPECIFY THE MANUFACTURER AND TEST KIT USED.

Reporting Individual: Name:_____ Date:_____

Title: _____ Telephone:_____ Fax: _____

Additional Comments: _____

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