Complete this form in Microsoft Word

|  |  |
| --- | --- |
| Facility Name: |  |
| Visitor Name: |  |
| Affected Unit(s): |  |
| Onset Date  The date the COVID test swab was done, or the date of onset of symptoms, whichever is earlier. |  |
| Positive Date  The date the COVID test result was reported |  |
| All visit dates from 48 hours before the Onset Date until the Positive Date |  |
| Investigator Name: |  |
| Investigator Phone: |  |
| Investigator E-mail: |  |

**Resident Exposures** – Interview and Visitor Log Review

Interview the visitor, resident(s), and staff to identify the residents who had contact for longer than 15 minutes with the visitor, starting 48 hours before the Onset Date until the 14 days after the Onset Date or the last visit to the facility, whichever is earlier. *(Press Tab in last column to add a new row)*

**Test Type: ( ) PCR** (preferred) **( ) Antigen ( ) Both**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Resident Name | Resident Unit & Room # | First Exposure Date  MM/DD | Last Exposure Date  MM/DD | Test Date #1  MM/DD | Test Date #2  MM/DD | Test Date #3  MM/DD | Test Date #4 (if needed)  MM/DD | (Q)uarantine or (M)asking? | Precautions or Masking End Date (if all tests are negative)  MM/DD |
|  |  |  |  |  |  |  |  |  |  |

**Staff Contacts** – Interview and Visitor Log Review

Interview the visitor, resident(s), and staff to identify the staff who had contact for longer than 15 minutes with the visitor, starting 48 hours before the Onset Date until the 14 days after the Onset Date or the last visit to the facility, whichever is earlier. *(Press Tab in last column to add a new row)*

**Test Type: ( ) PCR ( ) Antigen** (preferred) **( ) Both**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Staff Name & Role | Staff Unit or Department | First Exposure Date  MM/DD | Last Exposure Date  MM/DD | Test Date #1  MM/DD | Test Date #2  MM/DD | Test Date #3  MM/DD | Test Date #4 (if needed)  MM/DD | Masking ending date  MM/DD |
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