★ MIHMCI
☐ INPATIENT
☐ EMPLOYEE

Metro Iloilo Hospital & Medical Center, Inc

COVID-19 TESTING LABORATORY

CASE INVESTIGATION FORM (COVID-19)

☐ GRD FLOOR
☐ 3RD FLOOR
☐ COVID LAB

☐ SG-A ☐ SG-B ☐ SG-C ☐ SG-D ☐ SG-E ☐ SG-F ☐ SG-G ☐ SG-H ☐ SG-I ☐ SG-J

CovidID:	Close Contact: ( ) Yes ( ) No	Name of Close Contact/PH Code	
Disease Reporting Unit/Hospital:		Name of Investigator:	Date of Interview:

1. Patient Profile

Last Name	First Name	Middle Name	Suffix	Birthdate	Age	Sex: ( ) Male ( ) Female

Health Worker : Yes ( ) No ( )	Occupation	Civil Status	Nationality	Philhealth No.:	Passport No.

☐ Repatriate
☐ Authorized Person Outside Residence (APOR)
☐ Locally Stranded Individual (LSI)

☐ Travel Purpose
☐ PRE OR/PRE Procedure
☐ Personal
Others:

☐ Health Facility ☐ Quarantine Facility (TTMF) ☐ Home Quarantine
Name of Quarantine/Health Facility: ______
Address of Quarantine/Health Facility: ______

2. Philippine Residence

2.1. Permanent Address

House No./Lot/Bldg.	Street/Barangay	Municipality/City	Province
Region	Home Phone No.	**Cellphone No.**	Email address (for result)

2.2. Current Address

House No./Lot/Bldg.	Street/Barangay	Municipality/City	Province
Region	Home Phone No.	Work Phone No.	Other Email address

3. Address Outside the Philippines (for Overseas Filipino Workers and Individuals with Residence Outside the Philippines)

Employer's Name:	Occupation	Place of Work:	
House No./Bldg. Name	Street	City/Municipality	Province
Country:	Office Phone No.:	Cellphone No.:	

4. Travel History

History of travel/visit/work in other countries with a known COVID-19 transmission 14 days before the onset of your signs and symptoms:	( ) Yes ( ) No	Port (Country) of exit:	
Airline/Sea vessel:	Flight/Vessel Number:	Date of Departure (mm/dd/yyyy)	Date of Arrival in Philippines:

5. Exposure History

History of **Exposure to Known COVID-19 Case** 14 days before the onset of signs and symptoms: ( ) Yes ( ) No ( ) Unknown	If yes: Date of Contact with Known COVID-19 Case (mm/dd/yyyy):
Have you been in a **place with a known COVID-19 transmission** 14 days before the onset of signs and symptoms: ( ) Yes ( ) No ( ) Unknown	If yes: Place: ( ) Work place ( ) Health facility ( ) Social gathering ( ) Religious gathering ( ) Others: specify type: ______ Date when you have been in that place: Name of the place:
List the names of persons who were with you during this (these) occasion(s) and their contact numbers: *Use the back part of this sheet when needed*	Name/Contact number

6. Clinical Information

Disposition at Time of Report ( ) Admitted/Inpatient ( ) Outpatient ( ) Discharged ( ) Died ( ) Unknown

Fever ________°C ( ) Cough ( ) Sore throat ( ) Colds ( ) Shortness/difficulty of breathing ( ) Diarrhea/LBM

Date of Onset of Illness (mm/dd/yyyy): Or Date of Specimen Collection (*for Asymptomatics*)	Date of Admission/Consultation (mm/dd/yyyy):
Other signs/symptoms, specify	Is there any history of other illness? ( ) Yes ( ) No If YES, specify:
Chest X-ray done? ( ) Yes ( ) No If yes, when? ______	Are you pregnant? ( ) Yes ( ) No LMP ______ Assessed as High Risk? ( ) Yes ( ) No
CXR Results: Pneumonia ( ) Yes ( ) No ( ) Pending	Other Radiologic Findings:

7. Specimen Information

Specimen Collected	Date Collected	Date Received	Date Sent to Test Facility	Type of Medium	Date Result Released byTesting Facility	Date Result Received: RESU	PCR Result
NPS/OPS1							
NPSOPS2							
NPS/OPS3							
SERUM							
SPUTUM							

8. Classification

( ) Suspect Case ( ) Probable Case ( ) Confirmed Case

9. Outcome

Date of Discharge (mm/dd/yyyy):	Condition on Discharge: ( ) Improved ( ) Recovered ( ) Transferred ( ) Absconded ( ) Died Date died: ___/___/___	
Name of Informant: (if patient not available)	Relationship:	Phone No.

I Hereby give my consent to send or transmit my health data or information to the Department of Health as mandated by **RA 11332** until it is revoked by myself or my duly authorized representative

______
Signature

REQUISITIONER/DOCTOR:
HOSPITAL IN ILOILO CITY / PROVINCE CHO / DRU:
RHU (RURAL HEALTH UNIT):

FOR COMPANY/PRIVATE INSTITUTION ONLY

COMPANY/PRIVATE INSTITUTION:
COMPANY/PRIVATE INSTITUTION EMAIL: