-Continuum of Care – COVID Form – (2021)

Client ID:	Program Name:
Client Location: LA - 503	
After discharge do you have a safe living situation to return to?	☐ Safe Living Situation ☐ No Safe Living Situation
Select 'Yes' if client shows symptoms consistent with COVID-19. Leave blank and move to Additional Information section if not symptomatic.	
Are you experiencing symptoms consistent with COVID-19 (fever, cough, shortness of breath)?	☐ Yes ☐ No
When did your symptoms begin?	
When did you begin your isolation?	
When did you begin your quarantine?	
If hospitalized, what date were you admitted to the hospital?	
If known, what is the COVID-19 test result or confirmed disease status?	☐ Negative ☐ Positive ☐ Unknown
If tested for COVID-19, when were you tested?	
Testing Location Referred To:	
If tested for COVID-19, what date were the test results provided to you?	
What is your current symptomatic disposition?	☐ Currently Symptomatic ☐ No Longer Symptomatic ☐ Confirmed Recovery ☐ Deceased
What is the date of your current symptomatic disposition?	
Date Referred to Testing:	
Clinical Health Notes:	

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