COVID-19 Diagnosis Validation

Based on your professional medical judgement and review of the clinical indicators listed below, can you confirm this diagnosis? Please complete by selecting one of the options below.

☐ COVID-19 is ruled in (if so, please provide the evidence used to support this diagnosis) _____

☐ COVID-19 has been ruled out

☐ Other explanation of clinical findings* _____

☐ Unable to determine

☐ No further clarification needed

Statement of Issue (Reason for the query, please include date and location of documentation): _____

_____

Signs and Symptoms: (check all that apply)

☐ Lethargy:** _____

☐ Respiratory distress/failure:** _____

☐ Weight loss:** _____

☐ Fever:** _____

☐ Vomiting:** _____

☐ Diarrhea:** _____

☐ Cough:** _____

☐ Sore throat:** _____

☐ Loss of taste:** _____

☐ Loss of smell:** _____

☐ Other:*** _____

Risk Factors: (check all that apply)

☐ Diabetes:** _____

☐ Hypertension:** _____

☐ Asthma:** _____

☐ COPD:** _____

☐ Immunocompromised:** _____

☐ Age:** _____

☐ Tobacco use:** _____

☐ Recent travel:** _____

☐ Other:*** _____

**Please specify.*
***Specify where documentation is found.*
****Specify the other sign and symptom and where it is in the medical record.*

Treatment: (check all that apply)

- ☐ Bowel Rest:** _____
- ☐ Oxygen:** _____
- ☐ IV fluids:** _____
- ☐ IV antibiotics:** _____
- ☐ Isolation:** _____
- ☐ Quarantine:** _____
- ☐ Sepsis work-up:** _____
- ☐ Other:***_____

Other: (specify any other documentation related to COVID-19 and this query) _____

_____

***Specify where documentation is found.*
****Specify the other sign and symptom and where it is in the medical record.*

