Last Name: _____

First Name: _____

DOB: _____ *(dd/mm/yyyy)*

COVID-19 Contact Tracing Form

Community Stage: _____

For RCDC/TCDS/EPI Use only: Case # _____

Community: Home _____

Current _____

Contact of: _____

Date of case symptom onset (or test collection date if asymptomatic): *(dd/mm/yyyy) @ 24-hour clock*

☐ **Person Under Investigation**

☐ **Confirmed Case (that meets criteria for contact tracing)**

Identify and list ALL contacts:

From: _____ **(48 hrs prior or as directed)**
(dd/mm/yyyy) @ 24-hour clock

To: _____ Date and Time now
(dd/mm/yyyy) @ 24-hour clock

Please refer to Pg. 11 and 12 in the V8 protocol for more information on what constitutes a high and low risk exposure.

Name of Contact (Last Name, First name)	**DOB** (dd/mm/yyyy) **Age**	**Sex** M/F/ other	**Vaccines recieved**	**Phone Number(s)**	**Community/ House #**	**Date and type of last contact** (dd/mm/yyyy)	**Relationship, setting or type of contact with case**	**Symptomatic** (Y/N) **and** onset date dd/mm/yyyy	**PUI form Completed** (dd/mm/yyyy)	**Testing indicated Y/N If yes: date done** (dd/mm/yyyy)	**Precautions Indicated (type) Date started:** (dd/mm/yyyy
#1				H: C:		☐ High _____ ☐ Low_____					
#2				H: C:		☐ High _____ ☐ Low_____					

Details about contact with the case (e.g: same household, baby sitting, house-visiting, work place)

Symptom inquiry for the **contact** under investigaton (**not** the source case)

Please refer to Appendix D for criteria on when a PUI should be generated.

Follow COVID-19 Healthcare Provider Flowchart for guidance on lab testing and precautions.

Precaution types:
- Isolation
- Self-Monitoring
- N/A

Reporting Clinician Name _____

Date Completed_____ Date and Time now

Contact Information_____

Note: This PDF fillable must be opened in Adobe Acrobat or it will not work correctly. It can also be printed and scanned.

Last Name: _____

First Name: _____

DOB: _____ *(dd/mm/yyyy)*

COVID-19 Contact Tracing Form

Continued…

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Remove Page 2

Name of Contact (Last Name, First Name)	DOB (dd/mm/yyyy) / Age	**Sex** (M/F/ other)	**Vaccines recieved**	Phone Number(s)	Community/ House #	Date and type of last Contact (dd/mm/yyyy)	**Relationship,** Setting or type of contact with case	Symptomatic (Y/N) **and** onset date dd/mm/yyyy	PUI form Completed (dd/mm/yyyy	Testing Indicated (Y/N) If yes, collected on (dd/mm/yyyy)	Precautions Indicated (type) Date started: (dd/mm/yyyy)
#3				H: C:		☐ High _____ ☐ Low_____					
#4				H: C:		☐ High _____ ☐ Low_____					
#5				H: C:		☐ High _____ ☐ Low_____					
#6				H: C:		☐ High _____ ☐ Low_____					
#7				H: C:		☐ High _____ ☐ Low_____					
#8				H: C:		☐ High _____ ☐ Low_____					

Additional information on contacts (e.g. gatherings while infectious, possible links between contacts not clearly indicated above or more information):

Reporting Clinician Name _____ Date Completed_____ Contact Information_____

Date and Time now