Appendix 6: Close Contact Daily Clinical Update Form

Contact Information		
Name of contact:	Date of birth:	
Date of last exposure to case:	Estimated isolation period end date:	Contact Risk level: ☐High-risk ☐Self-isolation OR ☐Low-risk ☐Self-monitoring
COVID-19 test collection date:	COVID-19 test result:	Number of days between exposure and test collection date:
Received COVID-19 vaccination: ☐Yes ☐No	If yes, please complete the following:	Date of vaccination: Dose #1 _____ Dose #2_____ Vaccine product: ☐Moderna ☐Pfizer- BioNTeach
Existing medical conditions:		

Follow Up Date	Symptoms	Counselling/Needs/Referrals	Additional Comments	Signature of Interviewer
	☐Yes Date of onset: _____ ☐No ☐Resolved Symptoms:	☐ Self-isolate ☐ Self-monitor ☐ Testing recommended ☐ Contact CHN if symptoms develop or worsen ☐ Seek medical attention, including emergency care as required ☐ Discussed follow up plan ☐ Identified supports needed to self-isolation Identified needs: Referrals made:		
	□ Yes Date of onset: _____ □ No □ Resolved Symptoms:	☐ Self-isolate ☐ Self-monitor ☐ Testing recommended ☐ Contact CHN if symptoms develop or worsen ☐ Seek medical attention, including emergency care as required ☐ Discussed follow up plan ☐ Identified supports needed to self-isolation Identified needs: Referrals made:		

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Progress Notes	
Date	Comments