

## Notification COVID-19 Discharge or Death Form

This form has been adapted from Shared Health's Discharge form.

Please fax this form and the patient demographics sheet to Public Health at 204-428-2734, and to site Infection Prevention and Control.

Date of Symptom Onset: \_\_\_\_\_

Date of Positive COVID-19 Testing: \_\_\_\_\_

### **DISCHARGE:**

Date of Discharge: \_\_\_\_\_

Date When Self-Isolation Should End: \_\_\_\_\_

Date Recovered: \_\_\_\_\_

### **DECEASED:**

Date and Time of Death: \_\_\_\_\_

Cause of Death: \_\_\_\_\_

Underlying Medical Conditions: \_\_\_\_\_