| | General Quality Form | | Document Code:<br>Revision: 00<br>Effectivity Date: |
|---|---|---|---|
| | Division Memorandum | | Name of Office:<br>**SDO-ADMIN-Section** |

**DIVISION MEMORANDUM**

No. 244 S. **2020**

RELEASED Time/Date: 07-01-20 1:26PM By:

TO : **ELEMENTARY AND SECONDARY SCHOOL HEADS**
**ADMINISTRATIVE OFFICERS**
**UNIT/SECTION HEADS**
**ALL SEF PAID PERSONNEL**
**ALL OTHERS CONCERNED**

FROM : **MARIE CAROLYN B. VERANO, CESO VI**
Schools Division Superintendent

SUBJECT : **(SEF) RAPID DIAGNOSTIC TEST FOR COVID-19**

DATE : **June 30, 2020**

---

1. The City Government of Baguio will be conducting ***Rapid Diagnostic Test for COVID-19*** on ***July 6, 2020*** from ***9:00 am to 4:00 pm*** at the ***Auditorium, Baguio City High School, Gov. Pack Road, Baguio City.***

2. In relation to this, all SEF-paid personnel are enjoined to submit themselves to the said procedure.

3. Please bring with you the accomplished ***Case Investigation Form*** *(numbers 1 to 6 only)* on the day of the test. *

4. Immediate dissemination of and strict compliance to this memorandum is directed.

**see attached file

**MARIE CAROLYN B. VERANO, CESO V**
Schools Division Superintendent

Philippine Integrated Disease Surveillance and Response

# Case Investigation Form
# Coronavirus Disease (COVID-19)

| Disease Reporting Unit/Hospital: | Name of Investigator: | Date of Interview: |
|---|---|---|

**1. Patient Profile**

| Last Name | First Name | Middle Name | Birthday (mm/dd/yyyy) | Age | Sex: ( ) Male ( ) Female |
|---|---|---|---|---|---|
| Occupation | Civil Status | Nationality | | Passport No. | |

**2. Philippine Residence**

**2.1. Permanent Address**

| House No./Lot/Bldg. | Street/Barangay | Municipality/City | Province |
|---|---|---|---|
| Region | Home Phone No. | Cellphone No. | Email address |

**2.2. Current Address**

| House No./Lot/Bldg. | Street/Barangay | Municipality/City | Province |
|---|---|---|---|
| Region | Home Phone No. | Work Phone No. | Other Email address |

**3. Address Outside the Philippines (for Overseas Filipino Workers and Individuals with Residence Outside the Philippines)**

| Employer's Name: | Occupation | Place of Work: | |
|---|---|---|---|
| House No./Bldg. Name | Street | City/Municipality | Province |
| Country: | Office Phone No.: | Cellphone No.: | |

**4. Travel History**

| **History of travel/visit/work in other countries with a known COVID-19 transmission** 14 days before the onset of your signs and symptoms: ( ) Yes ( ) No | Port (Country ) of exit: | | |
|---|---|---|---|
| Airline/Sea vessel: | Flight/Vessel Number: | Date of Departure (mm/dd/yyyy) | Date of Arrival in Philippines: |

**5. Exposure History**

| History of **Exposure to Known COVID-19 Case** 14 days before the onset of signs and symptoms: ( ) Yes ( ) No ( ) Unknown | If yes: Date of Contact with Known COVID-19 Case (mm/dd/yyyy): |
|---|---|
| Have you been in a **place with a known COVID-19 transmission** 14 days before the onset of signs and symptoms: ( ) Yes ( ) No ( ) Unknown | If yes: Place: ( ) Work place ( ) Health facility ( ) Social gathering ( ) Religious gathering ( ) Others: specify type: _____ Date when you have been in that place: Name of the place: |

List the names of persons who were with you during this (these) occasion(s) and their contact numbers:
*Use the back part of this sheet when needed*

| | Name | Contact number |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

**6. Clinical Information**

Disposition at Time of Report ( ) Inpatient ( ) Outpatient ( ) Discharged ( ) Died ( ) Unknown

| Date of Onset of Illness (mm/dd/yyyy): | Date of Admission/Consultation (mm/dd/yyyy): |
|---|---|
| Fever _____°C ( ) Cough ( ) Sore throat ( ) Colds ( ) Shortness/difficulty of breathing | |
| Other signs/symptoms, specify | Is there any history of other illness? ( ) Yes ( ) No If YES, specify: |
| Chest X-ray done? ( ) Yes ( ) No If yes, when? _____ | Are you pregnant? ( ) Yes ( ) No LMP _____ Assessed as High Risk? ( ) Yes ( ) No |
| CXR Results: Pneumonia ( ) Yes ( ) No ( ) Pending | Other Radiologic Findings: |

**7. Specimen Information**

| Specimen Collected | If YES, Date Collected (mm/dd/yyyy) | Date sent to RITM (mm/dd/yyyy) | Date received in RITM *(to be filled up by RITM)* | Virus Isolation Result | PCR Result |
|---|---|---|---|---|---|
| ( ) Serum | ___/___/___ | ___/___/___ | ___/___/___ | | |
| ( ) Oropharyngeal/ Nasopharyngeal swab | ___/___/___ | ___/___/___ | ___/___/___ | | |
| ( ) Others | ___/___/___ | ___/___/___ | ___/___/___ | | |

**8. Classification**

( ) Suspect Case ( ) Probable Case ( ) Confirmed Case

**9. Outcome**

| Date of Discharge (mm/dd/yyyy): | Condition on Discharge: ( ) Improved ( ) Recovered ( ) Transferred ( ) Absconded ( ) Died |
|---|---|
| Name of Informant: (if patient not available) | Relationship: Phone No. |