PUTNAM COUNTY DEPARTMENT OF HEALTH
1 Geneva Road, Brewster, NY 10509 ■ 845-808-1390
www.putnamcountyny.gov/health [FAX: 845-279-4104]
A PHAB-ACCREDITED HEALTH DEPARTMENT

MaryEllen Odell
COUNTY EXECUTIVE

Michael J. Nesheiwat, MD
COMMISSIONER OF HEALTH

Contact Report

Please complete this form for each laboratory confirmed COVID-19 patient

Fax to 845-279-4104

LABORATORY CONFIRMED COVID-19 PATIENT INFORMATION

First Name: _____ Last Name: _____

DOB: _____/_____/_____ Age: _____Years/Months Sex: ◯Male ◯Female

CONTACT INFORMATION # 1

First Name: _____ Last Name: _____

Phone: _____ DOB: _____/_____/_____

Address: _____ City/Town: _____

Zip Code: _____ County: _____ Date of Last Contact: _____/_____/_____

GUARDIAN INFORMATION (IF CONTACT IS A MINOR)

First Name: _____ Last Name: _____

Phone: _____ Alternate Phone Number: _____

Address: _____ City/Town: _____

Zip Code: _____ County: _____ Relationship to Patient: _____

CONTACT INFORMATION # 2

First Name: _____ Last Name: _____

Phone: _____ DOB: _____/_____/_____

Address: _____ City/Town: _____

Zip Code: _____ County: _____ Date of Last Contact: _____/_____/_____

GUARDIAN INFORMATION (IF CONTACT IS A MINOR)

First Name: _____ Last Name: _____

Phone: _____ Alternate Phone Number: _____

Address: _____ City/Town: _____

Zip Code: _____ County: _____ Relationship to Patient: _____

CONTACT INFORMATION # 3

First Name: _____ Last Name: _____

Phone: _____ DOB: _____/_____/_____

Address: _____ City/Town: _____

Zip Code: _____ County: _____ Date of Last Contact: _____/_____/_____

GUARDIAN INFORMATION (IF CONTACT IS A MINOR)

First Name: _____ Last Name: _____

Phone: _____ Alternate Phone Number: _____

Address: _____ City/Town: _____

Zip Code: _____ County: _____ Relationship to Patient: _____

CONTACT INFORMATION #4

First Name: _____ Last Name: _____

Phone: _____ DOB: _____/_____/_____

Address: _____ City/Town: _____

Zip Code: _____ County: _____ Date of Last Contact: _____/_____/_____

GUARDIAN INFORMATION (IF CONTACT IS A MINOR)

First Name: _____ Last Name: _____

Phone: _____ Alternate Phone Number: _____

Address: _____ City/Town: _____

Zip Code: _____ County: _____ Relationship to Patient: _____

CONTACT INFORMATION #5

First Name: _____ Last Name: _____

Phone: _____ DOB: _____/_____/_____

Address: _____ City/Town: _____

Zip Code: _____ County: _____ Date of Last Contact: _____/_____/_____

GUARDIAN INFORMATION (IF CONTACT IS A MINOR)

First Name: _____ Last Name: _____

Phone: _____ Alternate Phone Number: _____

Address: _____ City/Town: _____

Zip Code: _____ County: _____ Relationship to Patient: _____