CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Only use this form for reporting COVID-19. Report to local health department within one working day.

DISEASE BEING REPORTED: COVID-19

Please write all dates as (mm/dd/yyyy)

Patient Name - Last Name | ***First Name*** | ***MI***

Home Address: Number, Street | ***Apt./Unit No.***

City | ***State*** | ***ZIP Code***

Home Telephone Number | ***Cell Telephone Number*** | ***Work Telephone Number***

Email Address | ***Country of Birth*** | ***Primary Language*** ☐ English ☐ Spanish ☐ Other: ____________

Birth Date *(mm/dd/yyyy)* | ***Age*** Years Months Days

Current Gender Identity

- ☐ Male
- ☐ Female
- ☐ Trans male / transman
- ☐ Trans female / transwoman
- ☐ Genderqueer or non-binary
- ☐ Identity not listed (specify):________________
- ☐ Declined to answer

Sex Assigned at Birth

☐ Male ☐ Female ☐ Declined to answer

Pregnant?

Yes No Unknown

If Yes, Est. Delivery Date: ______________

Sexual Orientation

- Heterosexual or straight
- Bisexual
- Gay, lesbian, or same gender loving
- Orientation not listed (specify): ________________
- Questioning / unsure / client doesn't know
- Declined to answer

Gender(s) of sex partners (check all that apply)

- Male
- Female
- Trans male / transman
- Trans female / transwoman
- Genderqueer or non-binary
- Identity not listed (specify):________________
- Declined to answer

Ethnicity (check one)

☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)

- ☐ African-American/Black
- ☐ American Indian/Alaska Native
- ☐ Asian *(check all that apply)*
  - ☐ Asian Indian ☐ Hmong ☐ Thai
  - ☐ Cambodian ☐ Japanese ☐ Vietnamese
  - ☐ Chinese ☐ Korean ☐ Other (specify): ____________
  - ☐ Filipino ☐ Laotian
- ☐ Pacific Islander *(check all that apply)*
  - ☐ Native Hawaiian ☐ Samoan
  - ☐ Guamanian ☐ Other (specify): ________
- ☐ White
- ☐ Other (specify): ________________ ☐ Unknown

Close contact with a laboratory confirmed COVID-19 case?

Yes No Unknown

If Yes, type of contact:

- Household contact
- Community contact
- Any healthcare contact
- Workplace contact

Additional Contact Details *(if applies)*

Congregate setting *(check if applies)*

Staff Resident Unknown

- Assisted Living Facility
- Skilled Nursing Facility
- Shelter
- Correctional Facility
- Hospital-Based Facility
- Clinic
- Other (specify):

Name,City of Congregate Setting(s) *(if applies):*

Occupation or Job Title

Healthcare worker In healthcare setting

Housing Status

Stable Unstable Unknown

Reporting Health Care Provider | ***Reporting Health Care Facility***

Address: Number, Street | ***Suite/Unit No.***

City | ***State*** | ***ZIP Code***

Telephone Number | ***Fax Number***

Email Address: | ***Date Submitted***

REPORT TO:

(Obtain additional forms from your local health department.)

Laboratory Name | ***City*** | ***State*** | ***ZIP Code***

Continued on next page.

CONFIDENTIAL MORBIDITY REPORT – COVID-19 (continued)

Patient Name - Last Name	*First Name*	*MI*	*Birth Date (mm/dd/yyyy)*

COVID-19: Hospitalization Status and Diagnostic Testing

Diagnosis Date:

Status at Time of Report

☐ Hospitalized, ICU
☐ Intubated
Not Intubated
☐ Hospitalized, non-ICU
☐ Not Hospitalized
Deceased
Date of Death (if applies)

Complete dates where applies

Date Hospitalized (if ever hospitalized)

Date Discharged (if previously hospitalized)

Date Intubated (if ever intubated)

Status History

Ever Hospitalized?	☐ Yes	☐ No
Ever in ICU?	☐ Yes	☐ No
Ever Intubated?	☐ Yes	☐ No
Ever Placed on ECMO?	☐ Yes	☐ No

Respiratory Complications

Clinical or Radiologic Evidence of Pneumonia *(check all that apply)*

☐ None
☐ Clinical
☐ Radiologic

Clinical or Radiologic Evidence of ARDS *(check all that apply)*

☐ None
☐ Clinical
☐ Radiologic

Imaging performed *(check all that apply)*

☐ Chest X-Ray ______ Date Performed
☐ Chest CT Scan ______ Date Performed
☐ Other Chest Imaging Study ______ Date Performed

COVID-19 Testing (Complete all that apply)

☐ **PCR swab (NP and/or OP)**

______ Date Specimen(s) Collected

Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

☐ **Antigen Test name:**______

______ Date Specimen Collected

Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

☐ **Serology Test name:**______

______ Date Specimen Collected

Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

☐ **Other:**______

______ Date Specimen Collected

Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

☐ **Not tested for COVID-19**

COVID-19 Specific Treatment(s)

Drug, Dosage, Route	Date Initiated
Drug, Dosage, Route	Date Initiated
Drug, Dosage, Route	Date Initiated

Clinical Information

COVID-19 Symptoms (Check all that apply)

☐ None
☐ Chills
Sore throat
☐ Difficulty breathing
☐ Loss of smell
☐ Vomiting
Dermatologic finding
☐ Fever >100.4F, 38C
☐ Rigors
☐ Cough
☐ Muscle aches
☐ Loss of taste
Abdominal pain
Thromboses (e.g. stroke, DVT, PE)
Subjective fever
Runny nose
Shortness of breath
Headache
Nausea
Diarrhea

Other (specify): ______

Date of first symptom onset:______

Travel to or reside in an area with sustained, ongoing, community transmission of SARS-CoV-2?

Yes .No Unknown

*If yes, location(s):*______

Other diagnosis or etiology for respiratory condition?

Yes (specify):______ ☐ No

Chronic Conditions (Check all that apply)

☐ None
☐ Cardiovasc. disease
☐ Chronic lung disease
☐ Stroke
☐ Immunocompromised
☐ Former smoker
☐ Unknown
☐ Hypertension
☐ Chronic kidney disease
☐ Neurological/ neuro-developemental
☐ Obesity
☐ Current e-cigarette or vape use
☐ Diabetes
☐ Asthma
☐ Chronic liver disease
☐ Cancer
☐ Current smoker

Other (specify):______

Vaccination History

Received one or more doses of COVID-19 vaccine

Yes .No Unknown

Type of Vaccine (i.e., Pfizer, Moderna, etc.)

______ Date of Dose 1

______ Date of Dose 2

Additional Remarks