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

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

Sex Assigned at Birth
☐ Male ☐ Female ☐ 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

Pregnant?
Yes No Unknown

If Yes, Est. Delivery Date: ______________

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.

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)*	***Clinical or Radiologic Evidence of ARDS*** *(check all that apply)*
☐ None	☐ None
☐ Clinical	☐ Clinical
☐ Radiologic	☐ 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)**
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

☐ **Serology Test Name** ____________
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

☐ **Other**____________________________
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

Additional Remarks

Clinical Information

COVID-19 Symptoms (Check all that apply)

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

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	☐ Unknown	☐ Diabetes
☐ Cardiovasc. disease	☐ Hypertension	☐ Asthma
☐ Chronic lung disease	☐ Chronic kidney disease	☐ Chronic liver disease
☐ Stroke	☐ Neurological/ neuro-developemental	☐ Cancer
☐ Immunocompromised	☐ Obesity	☐ Current smoker
☐ Former smoker	☐ Current e-cigarette or vape use	

Other *(specify)*: ___________________________________