

# 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)**

<b>Patient Name - Last Name</b>		<b>First Name</b>		<b>MI</b>	<b>Ethnicity (check one)</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown	
<b>Home Address: Number, Street</b>				<b>Apt./Unit No.</b>		
<b>City</b>			<b>State</b>	<b>ZIP Code</b>		
<b>Home Telephone Number</b>		<b>Cell Telephone Number</b>		<b>Work Telephone Number</b>		
<b>Email Address</b>		<b>Country of Birth</b>		<b>Primary Language</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
<b>Birth Date (mm/dd/yyyy)</b>		<b>Age</b> _____ Years    _____ Months    _____ Days				
<b>Current Gender Identity</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans male / transman <input type="checkbox"/> Trans female / transwoman <input type="checkbox"/> Genderqueer or non-binary <input type="checkbox"/> Identity not listed (specify): _____ <input type="checkbox"/> Declined to answer		<b>Sexual Orientation</b> Heterosexual or straight Bisexual Gay, lesbian, or same gender loving Orientation not listed (specify): _____ Questioning / unsure / client doesn't know Declined to answer				
<b>Sex Assigned at Birth</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to answer		<b>Gender(s) of sex partners (check all that apply)</b> Male Female Trans male / transman Trans female / transwoman Genderqueer or non-binary Identity not listed (specify): _____ Declined to answer				
<b>Pregnant?</b> Yes    No    Unknown If Yes, Est. Delivery Date: _____						
<b>Congregate setting (check if applies)</b> Staff    Resident    Unknown Assisted Living Facility    Skilled Nursing Facility    Shelter Correctional Facility    Hospital-Based Facility    Clinic Other (specify): _____					<b>Occupation or Job Title</b> Healthcare worker    In healthcare setting	
<b>Name, City of Congregate Setting(s) (if applies):</b>					<b>Housing Status</b> Stable    Unstable    Unknown	
<b>Reporting Health Care Provider</b>		<b>Reporting Health Care Facility</b>				
<b>Address: Number, Street</b>				<b>Suite/Unit No.</b>		
<b>City</b>			<b>State</b>	<b>ZIP Code</b>		
<b>Telephone Number</b>		<b>Fax Number</b>				
<b>Email Address:</b>				<b>Date Submitted</b>		
<b>Laboratory Name</b>				<b>City</b>		<b>State</b> <b>ZIP Code</b>

**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)**

(Obtain additional forms from your local health department.)

*Continued on next page.*

