

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	Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown				
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 <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____					
Birth Date (mm/dd/yyyy)		Age <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days		Gender: Male <input type="checkbox"/> M to F Other: _____ Female <input type="checkbox"/> F to M					
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Unknown EDD				Gender(s) of sex partners (check all that apply): Male M to F Unknown Female F to M Declined to state					
Congregate setting (check if applies) <input type="checkbox"/> Staff <input type="checkbox"/> Resident Unknown <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Shelter <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Hospital-Based Facility <input type="checkbox"/> Clinic <input type="checkbox"/> Other (specify) _____				What is the patient's sexual orientation? Heterosexual Gay/Lesbian/Homosexual Bisexual Other Unknown Declined to state					
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		REPORT TO: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Additional Contact Details (if applies) <input type="checkbox"/> Household contact <input type="checkbox"/> Community contact <input type="checkbox"/> Any healthcare contact <input type="checkbox"/> Workplace contact					
Address: Number, Street									
City									
Telephone Number		Fax Number							
Email Address:		Date Submitted							
Laboratory Name		City		State ZIP Code					

(Obtain additional forms from your local health department.)

COVID-19: Hospitalization Status and Diagnostic Testing <i>Diagnosis Date:</i>		Clinical Information	
Status at Time of Report <input type="checkbox"/> Hospitalized, ICU <input type="checkbox"/> Intubated Not Intubated <input type="checkbox"/> Hospitalized, non-ICU <input type="checkbox"/> Not Hospitalized Deceased Date of Death (if applies) _____ Status History Ever Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Ever in ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No Ever Intubated? <input type="checkbox"/> Yes <input type="checkbox"/> No Ever Placed on ECMO? <input type="checkbox"/> Yes <input type="checkbox"/> No		COVID-19 Testing (Complete all that apply) <input type="checkbox"/> PCR swab (NP and/or OP) Result: <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Serology Test Name _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Other _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Not tested for COVID-19	
Complete dates where applies Date Hospitalized (if ever hospitalized) _____ Date Discharged (if previously hospitalized) _____ Date Intubated (if ever intubated) _____		COVID-19 Symptoms (Check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Fever >100.4F, 38C Subjective fever <input type="checkbox"/> Chills <input type="checkbox"/> Rigors Runny nose Sore throat <input type="checkbox"/> Cough Shortness of Breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Muscle aches Headache <input type="checkbox"/> Loss of smell <input type="checkbox"/> Loss of taste Nausea <input type="checkbox"/> 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 <input type="checkbox"/> Unknown If yes, location(s): _____ Other diagnosis or etiology for respiratory condition? Yes (specify): _____ <input type="checkbox"/> No	
Respiratory Complications Clinical or Radiologic Evidence of Pneumonia (check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Clinical <input type="checkbox"/> Radiologic Imaging performed (check all that apply) <input type="checkbox"/> Chest X-Ray _____ Date Performed <input type="checkbox"/> Chest CT Scan _____ Date Performed <input type="checkbox"/> Other Chest Imaging Study _____ Date Performed		COVID-19 Specific Treatment (s) Drug, Dosage, Route Date Initiated _____ Drug, Dosage, Route Date Initiated _____ Drug, Dosage, Route Date Initiated _____ Additional Remarks _____ _____ _____	
Clinical or Radiologic Evidence of ARDS (check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Clinical <input type="checkbox"/> Radiologic		Chronic Conditions (Check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Diabetes <input type="checkbox"/> Cardiovasc. disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic lung disease <input type="checkbox"/> Chronic kidney disease <input type="checkbox"/> Chronic liver disease <input type="checkbox"/> Stroke <input type="checkbox"/> Neurological/ neuro-developmental <input type="checkbox"/> Cancer <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Obesity <input type="checkbox"/> Current smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Current e-cigarette or vape use Other (specify): _____	