## **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  Home Address: Number, Street		First Name		Apt./Unit No	<b>М</b> І	Ethnicity (check  Hispanic/La  Race (check all t	itino N	on-Hispanic/Non-Latino Unknown		
City	State ZIP Code			American Indian/Alaska Native Asian (check all that apply)						
Home Telephone Number Ce	Vork Telepi	hone Number		Asian Indian Hmong Thai Cambodian Japanese Vietnames Chinese Korean Other (spe						
Email Address  Birth Date (mm/dd/yyyy)	Age	rth Primary Language  Years Months	glishSpai ner:	nish	Chinese Korean Other (specify):  Filipino Laotian Pacific Islander (check all that apply)  Native Hawaiian Samoan					
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	wal Orientation  Heterosexual or straight  Bisexual  Gay, lesbian, or same gender loving  Orientation not listed (specify):  Questioning / unsure / client doesn't know  Declined to answer  Ider(s) of sex partners (check all that apply)  Male				Guamanian Other (specify):					
Male Female Declined to ans  Pregnant?  Yes No Unknown  If Yes, Est. Delivery Date:		Female  Trans male / transman  Trans female / transwoman  Genderqueer or non-binary  Identity not listed (specify):  Declined to answer								
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 C	Reporting Health Care Facility			REPORT TO:					
Address: Number, Street Suite/Unit No.										
City	State ZIP Code									
Telephone Number Fax Numbe										
Email Address:		Date Submitted			(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	I MI	Birth Date (mm/dd/yyyy)			
			l				
COVID-19: Hospitalization	Status and Diagno	stic Testing Diagnosis Date	Clinical Information				
Status at Time of Report	Complete dates where applies	COVID-19 Testing (Comp	lete all that apply)	COVID-19 Symptoms (Check all that apply)			
Hospitalized, ICU	where applies	PCR swab (NP and/or	· OP)	None Fever >100.	.4F, 38C Subjective fever		
Intubated	Intubated Date Hospitalized			Chills Rigors	Runny nose		
Not Intubated	(if ever hospitalized)	Date Specimen(s) Co	llected	Sore throat Cough  Difficulty breathing Muscle ache	Shortness of breath es Headache		
Hospitalized, non-ICU	Date Discharged	Result: Positive	Indeterminate	Loss of smell Loss of taste	<u> </u>		
Not Hospitalized	(if previously hospitalized)	Negative Negative	Pending	Vomiting Abdominal p			
Deceased  Date of Death	 Date Intubated	Antigen Test name	:		s (e.g. stroke, DVT, PE)		
(if applies)	(if ever intubated)			Other (specify):			
Status History		Date Specimen Collec	cted				
Ever Hospitalized?	Yes No	Result: Positive	Indeterminate	Date of first symptom onset:			
Ever in ICU?	Yes No	Negative	Pending	Travel to or reside in an area with sustain	ned, ongoing, community		
Ever Intubated?	Yes No	Serology Test name	:	transmission of SARS-CoV-2?  Yes No Unknown			
Ever Placed on ECMO?	Yes No						
Respiratory Complications		Date Specimen Collec	cted	If yes, location(s):			
Clinical or Radiologic Clinical or Radiologic		Result: Positive Indeterminate		Other diagnosis or etiology for respiratory condition?			
	idence of ARDS	Negative	Pending	Yes (specify):	No		
	neck all that apply)			Chronic Conditions (Check all the	at apply)		
None Clinical	None Clinical	Other:	<del></del>	None Unknown	Diabetes		
Radiologic	Radiologic	Date Specimen Collec	oted .	Cardiovasc. disease Hypertension	n Asthma		
		Positive	Indeterminate	Chronic lung disease Chronic kidney	disease Chronic liver disease		
Imaging performed (check all	that apply)	Result: Negative	Pending	Stroke Neurological/neuro-develope	emental Cancer		
Chest X-Ray	Date Performed	Not tested for COVID	-19	Immunocompromised Obesity	Current smoker		
Chest CT Scan	Date i circimica			Former smoker Current e-cig	arette or vape use		
Criest CT Scari	Date Performed	COVID-19 Specific Treatn	nent(s)	Other (specify):			
Other Chest Imaging Study		- Barrier Breste	Data Initiated	Vaccination His	story		
	Date Performed	Drug, Dosage, Route	Date Initiated	Received one or more doses of COVID-1	19 vaccine		
		Drug, Dosage, Route	Date Initiated	Yes No Unknown			
		Brug, Boouge, Route	Bate illitated	Type of Vessins (i.e. Dizer Mederne et	Date of Dose 1		
		Drug, Dosage, Route	Date Initiated	Type of Vaccine (i.e., Pfizer, Moderna, et	.G.)		
		Drug, Dosage, Route	Date illitated		Date of Dose 2		
Additional Remarks		L		<u> </u>			
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## FAX THIS FORM TO 1-805-781-5543