

# 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>				
		<input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days				
<b>Current Gender Identity</b>			<b>Sexual Orientation</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			<input type="checkbox"/> Heterosexual or straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay, lesbian, or same gender loving <input type="checkbox"/> Orientation not listed (specify): _____ <input type="checkbox"/> Questioning / unsure / client doesn't know <input type="checkbox"/> Declined to answer			
<b>Sex Assigned at Birth</b>			<b>Gender(s) of sex partners (check all that apply)</b>			
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to answer			<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>Pregnant?</b>						
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, Est. Delivery Date: _____						
<b>Congregate setting (check if applies)</b>					<b>Occupation or Job Title</b>	
<input type="checkbox"/> Staff <input type="checkbox"/> Resident <input type="checkbox"/> 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): _____					<input type="checkbox"/> Healthcare worker <input type="checkbox"/> In healthcare setting	
<b>Name, City of Congregate Setting(s) (if applies):</b>					<b>Housing Status</b>	
					<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Unknown	
<b>Reporting Health Care Provider</b>			<b>Reporting Health Care Facility</b>			<b>REPORT TO:</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>	

(Obtain additional forms from your local health department.)

*Continued on next page.*

