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

Sex Assigned at Birth
☐ Male ☐ Female ☐ Declined to answer

Pregnant?
Yes No Unknown
If Yes, Est. Delivery Date: ________

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

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

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.

CONFIDENTIAL MORBIDITY REPORT – COVID-19 (continued)

Patient Name - Last Name	***First Name***	***MI***	***Birth Date*** *(mm/dd/yyyy)*

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)**

Date Specimen(s) Collected

Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

☐ **Antigen Test name:**____________

Date Specimen Collected

Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

☐ **Serology Test name:**____________

Date Specimen Collected

Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

☐ **Other:**_______________________

Date Specimen Collected

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

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):_________________________________

Vaccination History

Received one or more doses of COVID-19 vaccine

Yes .No Unknown

Type of Vaccine (i.e., Pfizer, Moderna, etc.)

Date of Dose 1

Date of Dose 2

Additional Remarks