CONTRA COSTA HEALTH SERVICES

2019-nCoV ID: 2

Specimen Sent to (Lab Name): 12

COVID-19 Confidential Morbidity Report (CMR)

If sending a specimen to Public Health Lab for testing, submit this form with PH Lab Requisition Form and specimen. This form replaces the CCHS PUI Form.

If reporting a case, complete and fax this form to Public Health at 925-313-6465, along with the COVID test result and H&P or Progress Note.

Patient Demographics

Last Name: Mitchell First Name: Brenda DOB (MM/DD/YYYY): 09/06/1996

Address: 27050 Wolfe Glens City: La Habra Zip: 90633

Phone: (714) 294-6853 Email: brendamitchell@gmail.com

Sex: ☐ Male ☑ Female ☐ Unknown ☐ Other

Ethnicity: ☐ Hispanic/Latino ☑ Non-Hispanic/Latino ☐ Not Specified

Race (check all that apply): ☐ Asian ☐ Am. Indian/Alaska Native ☐ Black ☐ Native Hawaiian/Other Pacific Islander ☑ White ☐ Unk

PMH (check all that apply): ☑ HTN ☐ Cardiovascular Disease ☑ Asthma ☐ COPD ☑ Emphysema ☑ Chronic Liver Disease ☐ Chronic Renal Disease ☑ Immune Compromised Condition: _____ ☐ Other: _____ ☑ Smoker

SOS (Sensitive Occupations & Settings)—High Priority for Testing and Reporting

Patient resides/ works/ spends time in a setting that serves vulnerable populations** ☑ No ☐ Yes

Facility Name: Mcclure Post Acute Setting Type: _____

Address: 2910 Mcclure st, Oakland CA 94609

** Settings where people live together or congregate closely in groups of 10 or more, such as residential care facilities, senior living facilities, shelters, day programs, group homes, or jails. Also includes patients who receive chemotherapy, dialysis, etc. in a healthcare facility. SOS does not include schools, preschools, or daycare facilities.

Patient is a Health Care Worker (HCW) or a First Responder? ☐ No ☑ Yes

Employer/Facility: Mcclure Post Acute Address: 2910 Mcclure st, Oakland CA 94609

Reporting Health Care Provider: Kendra Davis

Agency/Facility: Mcclure Post Acute

Address: 2910 Mcclure st, Oakland CA 94609

Phone: (060) 475-7840

Is the Patient?

☐ Pregnant, Est delivery date: _____

☐ Deceased, Date of Death: _____

Patient Given Home Isolation Instructions ☑ Yes

Is the Patient Hospitalized?

☐ Unknown

☑ No

☐ Yes and is

☐ Currently Hospitalized at Reporting Facility

☐ Currently at _____

During this illness, did the patient experience any of the following symptoms? Symptom Onset Date: 11/11/2020	Symptom Present?		
Fever >100.4F (38C)	☑ Yes	☐ No	☐ Unk
Subjective fever (felt feverish)	☑ Yes	☐ No	☐ Unk
Chills	☐ Yes	☐ No	☑ Unk
Muscle aches (myalgia)	☐ Yes	☑ No	☐ Unk
Sore throat	☐ Yes	☐ No	☑ Unk
Cough (new onset or worsening of chronic cough)	☐ Yes	☐ No	☑ Unk
Shortness of breath (dyspnea)	☐ Yes	☐ No	☑ Unk
Nausea or vomiting	☐ Yes	☐ No	☑ Unk
Abdominal pain	☐ Yes	☐ No	☑ Unk
Diarrhea (≥3 loose/looser than normal stools/24hr period)	☑ Yes	☐ No	☐ Unk
Other, specify:	☐ Yes	☐ No	☑ Unk

State of California—Health and Human Services Agency | California Department of Public Health

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: VANCE	First Name: ADAM	MI: E
Home Address: Number, Street: UNIT 3123 BOX 3812	Apt./Unit No.	
City: CITY OF INDUSTRY	State: CA	ZIP Code: 91715
Home Telephone Number: 6261147651	Cell Telephone Number: 626-824-2250	Work Telephone Number: NA
Email Address: ADAMVANCE537@YAHOO.COM	Primary Language: ☒ English ☐ Spanish ☐ Other:	
Birth Date (mm/dd/yyyy): 05/22/1965	Age: 55 ☒ Years ☐ Months ☐ Days	Gender: ☐ Male ☐ Female ☐ M to F Transgender ☒ F to M Transgender ☐ Other:
Pregnant? ☐ Yes ☒ No ☐ Unknown If yes, Estimated Delivery Date (mm/dd/yyyy):	Occupation or Job Title: PASSENGER TRANSPORT MANAGER ☐ Health Care Worker (check if yes) ☐ In Health Care Setting (check if yes)	
Country of Birth: USA		

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

Congregate Setting (check if applies) ☒ Staff ☐ Resident ☐ Unknown
☒ Assisted Living Facility ☐ Skilled Nursing Facility ☐ Shelter
☐ Correctional Facility ☐ Hospital-Based Facility
☐ Other

Name and City of Congregate Setting (s), if applies: BOND-LIN, CITY OF INDUSTRY

Close contact with a laboratory confirmed COVID-19 case? ☒ Yes ☐ No ☐ Unknown ☐ Household contact ☐ Community contact ☒ Healthcare setting contact ☐ Non-healthcare workplace	Housing Status ☒ Stably Housed ☐ Unstably housed ☐ Unknown	02/23/2021 Date of Diagnosis Date of Death (if applies)

Reporting Health Care Provider: SCOTT, JASON	Reporting Health Care Facility: SERENITY HOSPICE CARE PROV	
Address: Number, Street: 2139 TAPO ST.	Suite/Unit No.	
City: SIMI VALLEY	State: CA	ZIP Code: 93063
Telephone Number: 457-253-7037	Fax Number: 890-682-2607	
Email Address: JASONSCOTT102@SERENITY.ORG	Date Submitted: 02/20/2021	

REPORT TO:

(Obtain additional forms from your local health department.)

Laboratory Name: SERENITY HOSPICE CARE PROVIDER, INC.	City: SIMI VALLEY	State: CA	ZIP Code: 93063

COVID-19: Hospitalization Status and Diagnostic Testing

Status at Time of Report
☒ Hospitalized, ICU
☐ Intubated
☒ Not Intubated
☐ Hospitalized, non-ICU
☐ Not Hospitalized

Complete dates where applies
02/20/2021 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 — 02/22/2021 Date Performed
☐ Chest CT Scan — Date Performed
☐ Other Chest Imaging Study — Date Performed

COVID-19 Testing (Complete all that apply)

☐ Nasopharyngeal PCR swab
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
Date Collected / Date Resulted

☐ Oropharyngeal PCR Swab
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
Date Collected / Date Resulted

☒ Serology Test Name ELISA IgG
FDA/EUA approved ☒ Yes ☐ No ☐ Unknown
☐ IgM only ☒ IgG only ☐ IgM/IgG ☐ Unknown
Result: ☐ Positive ☐ Negative ☒ Indeterminate ☒ Pending
Date Collected / Date Resulted

☐ Other
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
Date Collected / Date Resulted

Clinical Information

COVID-19 Symptoms (Check all that apply)

☐ None	☐ Fever >100.4F, 38C	☒ Subjective fever
☒ Cough	☐ Sore throat	☐ Runny nose (Rhinorrhea)
☐ Shortness of breath	☐ Difficulty breathing	☐ Chills
☐ Rigors	☒ Headache	☐ Muscle aches (myalgias)
☒ Loss of smell	☐ Loss of taste	
☒ Nausea	☐ Abdominal pain	☒ Vomiting
☐ Other (specify):		☐ Diarrhea

Date of first symptom onset: 02/17/2021

Travel to COVID-19 Impacted area within 14 days of symptom onset? ☒ Yes ☐ No ☐ Unknown If yes, destination(s):

Other diagnosis or etiology for respiratory condition?
☒ Yes (specify): PALESTINIAN TERRITORY ☐ No

Chronic Conditions (Check all that apply)

☐ None	☐ Unknown	☐ Diabetes
☐ Cardiovascular disease	☐ Hypertension	☐ Chronic lung disease
☐ Chronic kidney disease	☐ Chronic liver disease	☐ Immuno-compromised
☒ Asthma	☐ Neurological/neuro-developments	☐ Cancer
☐ Obesity	☐ Current smoker	☐ Stroke

☐ Other (specify):

COVID-19 Specific Treatment (s)

Drug, Dosage, Route	Date Initiated
PEGAPTANIB 50mg ORAL	02/23/2021
EXEMESTANE 51mg ORAL	02/24/2021