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: ADAMVANCE5378@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 | | |
| 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 | Date of Diagnosis: 02/13/2021. Date of Death (if applies): |

**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: BOYD-LIN, CITY OF INDUSTRY

| | | |
|---|---|---|
| Reporting Health Care Provider: SCOTT, JASON | Reporting Health Care Facility: SERENITY HOSPICE CARE PROV | |
| Address: Number, Street: 2134 TARO ST. | Suite/Unit No. | |
| City: SIMI VALLEY | State: CA | ZIP Code: 93063 |
| Telephone Number: 457-253-7037 | Fax Number: 690-682-2607 | |
| 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:
Date Hospitalized (if ever hospitalized): 02/10/2021
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: 02/12/2021
- ☐ 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): PARAINFLUENZA ☐ No

**Chronic Conditions (Check all that apply)**

| | | |
|---|---|---|
| ☐ None | ☐ Unknown | ☐ Diabetes |
| ☐ Cardiovascular disease | ☐ Hypertension | ☐ Chronic lung disease |
| ☐ Chronic kidney disease | ☐ Chronic liver disease | ☐ Immunocompromised |
| ☒ Asthma | ☐ Neurological/neurodevelopmental | ☐ Cancer |
| ☐ Obesity | ☐ Current smoker | ☐ Stroke |

☐ Other (specify):

**COVID-19 Specific Treatment (s)**

| Drug, Dosage, Route | Date Initiated |
|---|---|
| PREDNISONE 50mg ORAL | 02/13/2021 |
| REMDESIVIR 5mg | 02/14/2021 |