CONTRA COSTA HEALTH SERVICES

2019-nCoV ID: 2

Specimen Sent to (Lab Name): 16

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: Garner First Name: Justin DOB (MM/DD/YYYY): 09/09/1976

Address: 70572 Sheryl Keys City: Simi Valley Zip: 93065

Phone: (805) 816-0715 Email: struggle pint @ hotmail.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: Sonrisas Dental Health, Inc. Setting Type: Household Contact

Address: 210 San Mateo Rd, Half Moon Bay CA 94019

** 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: Sonrisas Dental Health, Address: 210 San Mateo Rd, Half Moon Bay

Reporting Health Care Provider: Ronald Ramos, MD

Agency/Facility: Sonrisas Dental Health, Inc.

Address: 210 San Mateo Rd, Half Moon Bay CA

Phone: 401-827-9385

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: ____/____/____	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