CONTRA COSTA
HEALTH SERVICES

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

First Name:_____ Last Name:_____ DOB (MM/DD/YYYY): _____/_____/_____

Address: _____ City: _____ Zip: _____

Phone:_____ Email:_____

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

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: _____ Setting Type: _____

Address:_____

**Settings where people live together or congregate closely in groups of 10 or more, such as residential care facilities, senior r 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: _____ Address:_____

Reporting Health Care Provider:_____

Agency/Facility:_____

Address:_____

Phone: _____

Is the Patient?

☐ Pregnant

☐ Deceased

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 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