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

Gender: ☐ Male ☐ Female ☐ M to F ☐ F to M ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown *EDD*

Gender(s) of sex partners (check all that apply): ☐ Male ☐ Female ☐ M to F ☐ F to M ☐ Unknown ☐ Declined to state

Congregate setting (check if applies)
☐ Staff ☐ Resident ☐ Unknown
☐ Assisted Living Facility ☐ Skilled Nursing Facility ☐ Shelter
☐ Correctional Facility ☐ Hospital-Based Facility ☐ Clinic
☐ Other *(specify)*

What is the patient's sexual orientation?
☐ Heterosexual ☐ Gay/Lesbian/Homosexual ☐ Bisexual ☐ Other ☐ Unknown ☐ Declined to state

Name,City of Congregate Setting(s) (if applies):

Occupation or Job Title:
☐ Healthcare Worker ☐ In Healthcare Setting

Housing Status
☐ Stable ☐ Unstable ☐ Unknown

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 ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Thai ☐ Vietnamese ☐ Other *(specify):* _____
☐ Pacific Islander *(check all that apply)*
☐ Native Hawaiian ☐ Guamanian ☐ Samoan ☐ Other *(specify):* _____
☐ White
☐ Other *(specify):* _____ ☐ Unknown

Close contact with a laboratory confirmed COVID-19 case?
☐ Yes ☐ No ☐ Unknown *Additional Contact Details (if applies)*
☐ Household contact
☐ Community contact
☐ Any healthcare contact
☐ Workplace contact

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*

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 IDU?	☐ Yes	☐ No
Ever Intubated?	☐ Yes	☐ No
Ever Placed on ECMO?	☐ Yes	☐ No

Respiratory Complications

Clinical or Radiologic Evidence of Pneumonia (check all that apply)
☐ None
☐ Clinical
☐ Radiologic

Clinical or Radiologic Evidence of ARDS (check all that apply)
☐ None
☐ Clinical
☐ 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)
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

☐ Serology Test Name _____
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

☐ Other Anterior Nares
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

☐ *Not tested for COVID-19*

COVID-19 Specific Treatment (s)

Drug, Dosage, Route — Date Initiated
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Additional Remarks

Clinical Information

COVID-19 Symptoms (Check all that apply)

☐ None
☐ Chills
☐ Sore throat
☐ Difficulty breathing
☐ Loss of smell
☐ Vomiting
☐ Dermatologic finding
☐ Fever >100.4F, 38C
☐ Rigors
☐ Cough
☐ Muscle aches
☐ Loss of taste
☐ Abdominal pain
☐ Thromboses (e.g. stroke, DVT, PE)
☐ Subjective fever
☐ Runny nose
☐ Shortness of Breath
☐ Headache
☐ Nausea
☐ Diarrhea
☐ 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
☐ Cardiovasc. disease
☐ Chronic lung disease
☐ Stroke
☐ Immunocompromised
☐ Former smoker
☐ Unknown
☐ Hypertension
☐ Chronic kidney disease
☐ Neurological/ neuro-developemental
☐ Obesity
☐ Current e-cigarette or vape use
☐ Diabetes
☐ Asthma
☐ Chronic liver disease
☐ Cancer
☐ Current smoker
☐ Other *(specify):* _____