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

Current Gender Identity
- ☐ Male
- ☐ Female
- ☐ Trans male / transman
- ☐ Trans female / transwoman
- ☐ Genderqueer or non-binary
- ☐ Identity not listed (specify):_____
- ☐ Declined to answer

Sex Assigned at Birth
☐ Male ☐ Female ☐ Declined to answer

Pregnant?
Yes   No   Unknown

If Yes, Est. Delivery Date: _____

Sexual Orientation
- Heterosexual or straight
- Bisexual
- Gay, lesbian, or same gender loving
- Orientation not listed (specify): _____
- Questioning / unsure / client doesn't know
- Declined to answer

Gender(s) of sex partners (check all that apply)
- Male
- Female
- Trans male / transman
- Trans female / transwoman
- Genderqueer or non-binary
- Identity not listed (specify):_____
- Declined to answer

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

Close contact with a laboratory confirmed COVID-19 case?

Yes   No   Unknown

If Yes, type of contact:
- Household contact
- Community contact
- Any healthcare contact
- Workplace contact

Additional Contact Details (if applies)

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

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

Occupation or Job Title

Healthcare worker   In healthcare setting

Housing Status
Stable   Unstable   Unknown

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**

Laboratory Name   **City**   **State**   **ZIP Code**

REPORT TO:

(Obtain additional forms from your local health department.)

Continued on next page.

CONFIDENTIAL MORBIDITY REPORT – COVID-19 (continued)

Patient Name - Last Name	First Name	MI	Birth Date (mm/dd/yyyy)

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 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)
- ☐ 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)**

_____
Date Specimen(s) Collected

Result: ☐ Positive ☐ Indeterminate ☐ Negative ☐ Pending

☐ **Antigen   Test name:_____**

_____
Date Specimen Collected

Result: ☐ Positive ☐ Indeterminate ☐ Negative ☐ Pending

☐ **Serology   Test name:_____**

_____
Date Specimen Collected

Result: ☐ Positive ☐ Indeterminate ☐ Negative ☐ Pending

☐ **Other:_____**

_____
Date Specimen Collected

Result: ☐ Positive ☐ Indeterminate ☐ Negative ☐ Pending

☐ **Not tested for COVID-19**

COVID-19 Specific Treatment(s)

_____   _____
Drug, Dosage, Route   Date Initiated

_____   _____
Drug, Dosage, Route   Date Initiated

_____   _____
Drug, Dosage, Route   Date Initiated

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):_____

Vaccination History

Received one or more doses of COVID-19 vaccine

Yes   .No   Unknown

Type of Vaccine (i.e., Pfizer, Moderna, etc.)

_____
Date of Dose 1

_____
Date of Dose 2

Additional Remarks