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 ☐ M to F Other: Female ☐ F to M

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

Pregnant? ☐ Yes ☐ No Unknown *EDD*

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):*

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

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 ☐ 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 **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

Complete dates where applies

☐ Hospitalized, ICU
- ☐ Intubated
- Not Intubated

☐ Hospitalized, non-ICU
☐ Not Hospitalized
Deceased
Date of Death *(if 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)**
Result: ☐ Positive ☐ Indeterminate ☐ Negative ☐ Pending

☐ **Serology Test Name** ________
Result: ☐ Positive ☐ Indeterminate ☐ Negative ☐ Pending

☐ **Other**________________
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

Additional Remarks

Clinical Information

COVID-19 Symptoms (Check all that apply)

☐ None	☐ Fever >100.4F, 38C	Subjective fever
☐ Chills	☐ Rigors	Runny nose
Sore throat	☐ Cough	Shortness of Breath
☐ Difficulty breathing	☐ Muscle aches	Headache
☐ Loss of smell	☐ Loss of taste	Nausea
☐ Vomiting	Abdominal pain	Diarrhea
Dermatologic finding	Thromboses (e.g. stroke, DVT, PE)	

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	☐ Unknown	☐ Diabetes
☐ Cardiovasc. disease	☐ Hypertension	☐ Asthma
☐ Chronic lung disease	☐ Chronic kidney disease	☐ Chronic liver disease
☐ Stroke	☐ Neurological/ neuro-developemental	☐ Cancer
☐ Immunocompromised	☐ Obesity	☐ Current smoker
☐ Former smoker	☐ Current e-cigarette or vape use	

Other *(specify)*: ________