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***

REPORT TO:

Shasta County Health and Human Services Agency - Public Health Branch
2650 Breslauer Way
Redding, CA 96001

Phone during business hours: (530) 225-5591
*After hours and weekends:
(530) 395-0132 Fax: (530) 225-5074

(Obtain additional forms from your local health department.)

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

Continued on next page.

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 ☐ Negative ☐ Indeterminate ☐ Pending
- ☐ **Serology Test Name** _____
  Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
- ☐ **Other** _____
  Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
- ☐ ***Not tested for COVID-19***

COVID-19 Specific Treatment (s)

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)*: _____