

# 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)**

<b>Patient Name - Last Name</b>		<b>First Name</b>		<b>MI</b>	<b>Ethnicity (check one)</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown		
<b>Home Address: Number, Street</b>				<b>Apt./Unit No.</b>			
<b>City</b>			<b>State</b>	<b>ZIP Code</b>			
<b>Home Telephone Number</b>		<b>Cell Telephone Number</b>		<b>Work Telephone Number</b>			
<b>Email Address</b>		<b>Country of Birth</b>		<b>Primary Language</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			
<b>Birth Date (mm/dd/yyyy)</b>		<b>Age</b> <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days		<b>Gender:</b> Male <input type="checkbox"/> M to F    Other: _____ Female <input type="checkbox"/> F to M			
<b>Pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>EDD</b>				<b>Gender(s) of sex partners (check all that apply):</b> Male    M to F    Unknown Female    F to M    Declined to state			
<b>Congregate setting (check if applies)</b> <input type="checkbox"/> Staff <input type="checkbox"/> Resident <input type="checkbox"/> Unknown <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Shelter <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Hospital-Based Facility <input type="checkbox"/> Clinic <input type="checkbox"/> Other (specify): _____				<b>What is the patient's sexual orientation?</b> Heterosexual    Gay/Lesbian/Homosexual Bisexual    Other    Unknown    Declined to state			
<b>Name, City of Congregate Setting(s) (if applies):</b>				<b>Occupation or Job Title:</b> Healthcare Worker    In Healthcare Setting			
				<b>Housing Status</b> Stable    Unstable    Unknown			
<b>Reporting Health Care Provider</b>			<b>Reporting Health Care Facility</b>			<b>REPORT TO:</b>  <b>San Joaquin County Public Health Services</b> Fax: (209) 468-8222 Email: SJCDiseaseReporting@sjcphs.org  <span style="color: red;">Use secure transmission for emailed reports</span>	
<b>Address: Number, Street</b>			<b>Suite/Unit No.</b>				
<b>City</b>			<b>State</b>	<b>ZIP Code</b>			
<b>Telephone Number</b>		<b>Fax Number</b>					
<b>Email Address:</b>			<b>Date Submitted</b>				
<b>Laboratory Name</b>			<b>City</b>	<b>State</b>	<b>ZIP Code</b>		

COVID-19: Hospitalization Status and Diagnostic Testing <i>Date Collected:</i>		Clinical Information	
<b>Status at Time of Report</b> <input type="checkbox"/> Hospitalized, ICU <input type="checkbox"/> Intubated Not Intubated  <input type="checkbox"/> Hospitalized, non-ICU <input type="checkbox"/> Not Hospitalized  Deceased <b>Date of Death (if applies)</b>		<b>COVID-19 Testing (Complete all that apply)</b>  <b>PCR swab (NP and/or OP)</b> Result:    Positive    Indeterminate Negative    Pending  <b>Serology    Test Name</b> _____ Result:    Positive    Indeterminate Negative    Pending  Other _____ Result:    Positive    Indeterminate Negative    Pending  Not tested for COVID-19	
<b>Complete dates where applies</b>  Date Hospitalized (if ever hospitalized) _____  Date Discharged (if previously hospitalized) _____  Date Intubated (if ever intubated) _____		<b>COVID-19 Symptoms (Check all that apply)</b> <input type="checkbox"/> None <input type="checkbox"/> Fever >100.4F, 38C    Subjective fever <input type="checkbox"/> Chills <input type="checkbox"/> Rigors    Runny nose Sore throat <input type="checkbox"/> Cough    Shortness of Breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Muscle aches    Headache <input type="checkbox"/> Loss of smell <input type="checkbox"/> Loss of taste    Nausea <input type="checkbox"/> Vomiting    Abdominal pain    Diarrhea Dermatologic finding    Thromboses (e.g. stroke, DVT, PE) Other (specify): _____ <b>Date of first symptom onset</b> _____	
<b>Status History</b> Ever Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Ever in ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No Ever Intubated? <input type="checkbox"/> Yes <input type="checkbox"/> No Ever Placed on ECMO? <input type="checkbox"/> Yes <input type="checkbox"/> No		Travel to or reside in an area with sustained, ongoing, community transmission of SARS-CoV-2? Yes    No <input type="checkbox"/> Unknown    If yes, location(s): _____  <b>Other diagnosis or etiology for respiratory condition?</b> Yes (specify): _____ <input type="checkbox"/> No	
<b>Respiratory Complications</b> <b>Clinical or Radiologic Evidence of Pneumonia (check all that apply)</b> <input type="checkbox"/> None <input type="checkbox"/> Clinical <input type="checkbox"/> Radiologic <b>Clinical or Radiologic Evidence of ARDS (check all that apply)</b> <input type="checkbox"/> None <input type="checkbox"/> Clinical <input type="checkbox"/> Radiologic		<b>Chronic Conditions (Check all that apply)</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Diabetes <input type="checkbox"/> Cardiovasc. disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic lung disease <input type="checkbox"/> Chronic kidney disease <input type="checkbox"/> Chronic liver disease <input type="checkbox"/> Stroke <input type="checkbox"/> Neurological/ neuro-developmental <input type="checkbox"/> Cancer <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Obesity <input type="checkbox"/> Current smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Current e-cigarette or vape use Other (specify): _____	
<b>Imaging performed (check all that apply)</b> <input type="checkbox"/> Chest X-Ray    _____ Date Performed <input type="checkbox"/> Chest CT Scan    _____ Date Performed <input type="checkbox"/> Other Chest Imaging Study    _____ Date Performed		<b>COVID-19 Specific Treatment (s)</b> Drug, Dosage, Route    Date Initiated _____ Drug, Dosage, Route    Date Initiated _____ Drug, Dosage, Route    Date Initiated _____	
<b>Additional Remarks</b> _____ _____ _____			