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 Home Address: Number, Street		First Name Apt./Unit No					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)				
City		State ZIP Code									
Home Telephone Number Ce	Cell Telephone Number Work Telephone Number						Asian Indian Hmong Thai Cambodian Japanese Vietnamese				
Email Address	Country of	Birth	Primary Language	∏En	glish [Spanish	Laotian Laotian				
Birth Date (mm/dd/yyyy)	Age	Years	Months	Days			☐ Pacific Islander (check all that apply) ☐ Native Hawaiian ☐ Samoan ☐ Guamanian ☐ 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				
Current Gender Identity Male	S	Sexual Orie Heterose	ntation exual or strai	ght							
Female Trans male / transman Trans female / transwoman Genderqueer or non-binary Identity not listed (specify):		Orientation Question	bian, or same on not listed ning / unsure I to answer	(specify):							
Declined to answer	G	Gender(s) or	f sex partne	rs (check	all that a	pply)					
Sex Assigned at Birth Male Female Declined to ans Pregnant?	swer	Male Female Trans ma	ale / transma	an			Workplace contact Additional Contact Details (if applies)				
Yes No Unknown		Genderq	male / transv queer or non-	binary							
If Yes, Est. Delivery Date:	_	-	not listed (spe I to answer	еспу):							
Congregate setting (check if applies) Staff Resident Unknown Assisted Living Facility Skilled Nursing Facility Shelter						Occupation or Job Title Healthcare worker In healthcare setting					
Assisted Living Facility Correctional Facility Other (specify): Name, City of Congregate Setting(s) (if applies): Settler Clinic Clinic							Housing Status Stable Unstable Unknown				
Reporting Health Care Provider	ng Health C	are Facilit	v		REPORT TO:						
Address: Number, Street	Suite/Unit No.										
City			State	ZIP Cod	<u> </u>						
Telephone Number		Fax Number									
Email Address:		Date Submitted					(Obtain additional forms from your local health department.)				
Laboratory Name				Cit	у		State ZIP Code				

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		ostic Testing Diagnosis Date			Clinical Information								
Status at Time of Report Complete dates where applies		COVID-19 Testing (Compl	ete all that ap	oply)	COVID-19 Symptoms (Check all that apply)								
Hospitalized, ICU	where applies	PCR swab (NP and/or	OP)		None	Fever >100.4F, 38C	Subjective fever						
Intubated	Date Hospitalized				Chills	Rigors	Runny nose						
Not Intubated	(if ever hospitalized)	Date Specimen(s) Coll	lected		Sore throat	Cough	Shortness of breath						
Hospitalized, non-ICU	Date Discharged	Result: Positive	Indetermin	nate	Difficulty breathing		Headache						
■ Not Hospitalized	(if previously hospitalized)	Negative	Pending		Loss of smell	Loss of taste Abdominal pain	Nausea Diarrhea						
Deceased		Antigen Test name:				•							
Date of Death (if applies)	Date Intubated (if ever intubated)	Antigen rest name.			Dermatologic finding Thromboses (e.g. stroke, DVT, PE)								
Status History	(ii ever interaced)	Date Specimen Collect	ted		Other (specify):								
		Result: Positive	Indetermin	ate	Date of first symptom	onset:							
Ever Hospitalized?	Ever Hospitalized? Yes No		Pending		Travel to or reside in an	area with sustained, ongo	ning community						
Ever in ICU?					transmission of SARS-C		mig, community						
Ever Placed on ECMO? Yes No		Serology Test name:			Yes No L	Jnknown							
Every lassed on Estimot.		Date Specimen Collect	tod		If yes, location(s):_								
Respiratory Complication		·_			Other diagnosis or etiology for respiratory condition?								
Clinical or Radiologic Clinical or Radiologic Evidence of Pneumonia Evidence of ARDS		Result: Positive	Indetermin	ate	Yes (specify):		□ No						
(check all that apply) (check all that apply)			r onamg										
None	None	Other:			Chronic Conditions	(Check all that apply	<u></u>						
Clinical	Clinical			_	None	Unknown	Diabetes						
Radiologic	Radiologic	Date Specimen Collect	ted			Hypertension	Asthma						
Annual Control of the		Positive	Indetermin	nate	-	Chronic kidney disease Neurological/	Chronic liver disease						
Imaging performed (check all that apply)		Result: Negative	Pending		Stroke	neuro-developemental	Cancer						
Chest X-Ray	Date Performed	Not tested for COVID-	-19		Immunocompromised	Obesity	Current smoker						
					Former smoker	Current e-cigarette or	vape use						
Chest CT Scan	Date Performed	COVID-19 Specific Treatm	ient(s)		Other (specify):								
Other Chest Imaging Study Date Performed					Vaccination History								
		Drug, Dosage, Route	Date Initiated			loses of COVID-19 vaccine	e						
		Drug Dagge Bauta	Data Initiated			Jnknown							
		Drug, Dosage, Route	Date Initiated				Date of Dose 1						
			5		Type of Vaccine (i.e., Pf	izer, Moderna, etc.)							
		Drug, Dosage, Route	Date Initiated				Date of Dose 2						
A 1 1701 1 7 1													
Additional Remarks													