CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Only use this form for reporting COVID-19. Report to local health department within one working day.

Please write all dates as (mm/dd/yyyy) **DISEASE BEING REPORTED:** COVID-19 Patient Name - Last Name First Name МΙ Ethnicity (check one) Hispanic/Latino Non-Hispanic/Non-Latino Race (check all that apply) Home Address: Number, Street Apt./Unit No. African-American/Black City State ZIP Code American Indian/Alaska Native Asian (check all that apply) Asian Indian Hmong 🗌 Thai Cell Telephone Number Work Telephone Number Home Telephone Number Cambodian Japanese Vietnamese Chinese Korean Other (specify): Email Address Country of Birth Primarv English Spanish Filipino Laotian Language Other: Pacific Islander (check all that apply) Birth Date (mm/dd/yyyy) Age Native Hawaiian Samoan Years Months Days 🗌 Guamanian Other (specify): **Current Gender Identity** Sexual Orientation White Male Unknown Heterosexual or straight Other (specify): Female Close contact with a laboratory confirmed COVID-19 case? Bisexual Trans male / transman Gay, lesbian, or same gender loving Unknown Yes No Trans female / transwoman Orientation not listed (specify): If Yes, type of contact: Genderqueer or non-binary Questioning / unsure / client doesn't know Household contact Identity not listed (specify): Declined to answer Community contact Declined to answer Any healthcare contact Gender(s) of sex partners (check all that apply) Workplace contact Sex Assigned at Birth Male Male Female Declined to answer Female Additional Contact Details (if applies) Trans male / transman Pregnant? Trans female / transwoman Yes No Unknown Genderqueer or non-binary Identity not listed (specify):_ If Yes, Est. Delivery Date: Declined to answer Congregate setting (check if applies) Occupation or Job Title Staff Resident Unknown **Skilled Nursing Facility** Shelter Healthcare worker In healthcare setting Assisted Living Facility Hospital-Based Facility Clinic **Correctional Facility** Housing Status Stable Unknown Other (specify) Unstable Name, City of Congregate Setting(s) (if applies): Reporting Health Care Provider Reporting Health Care Facility **REPORT TO:** Address: Number, Street Suite/Unit No. City State ZIP Code Telephone Number Fax Number Date Submitted Email Address: (Obtain additional forms from your local health department.) City State ZIP Code Laboratory Name

Continued on next page.

Status at Time of Report Complete dates where applies COVID-19 Testing (Complete all that apply) COVID-19 Symptoms (Check all that apply) Hospitalized, ICU Date Hospitalized (ff ever hospitalized) Date Hospitalized (ff ever hospitalized) Perstive Indeterminate Rigors Runny nose Hospitalized, non-ICU Date Discharged (ff previously hospitalized) Positive Indeterminate Outlot -19 Symptoms (Check all that apply) None Sore throat Couplete alt spitalized Deceased Date Intubated If ever intubated Positive Indeterminate Not findeterminate Other	COVID-19: Hospitalization Status and Diagnostic Testing Diagnosis Date:				Clinical Information		
Hospitalized, ICU □			COVID-19 Testing (Complete all that apply)		COVID-19 Symptoms (Check all that apply)		
Initibated If ever hospitalized Not Intubated (if ever hospitalized) Hospitalized, non-ICU Date Discharged Not Hospitalized Date Discharged Intubated (if ever hospitalized) Deceased Date Intubated Date Discharged If ever intubated (if ever intubated Date Intubated (if ever intubated) Other Status History Other Ever Hospitalized? Yes Ever Intubated? Yes Ever Intubated? Yes Ever Placed on ECMO? Yes Clinical or Radiologic Clinical or Radiologic Evidence of Pneumonia Check all that apply) (check all that apply) Drug, Dosage, Route Date Initiated	Hospitalized, ICU	where applies	PCR swab (NP and/or	OP)	None		Subjective fever
Not Intubated Negative Pending Not Intubated Date Discharged Date Discharged Mospitalized If previously hospitalized Date Discharged Deceased Date Intubated Negative Positive Date of Death Date Intubated Negative Pending Mission Date Intubated Negative Pending Status History Date Intubated Not Hospitalized? Yes No Ever Hospitalized? Yes No Positive Indeterminate Result: Positive Indeterminate Positive Positive Ever in ICU? Yes No Not tested for COVID-19 Travel to or reside in an area with sustained, ongoing, community transmission of SARS-CoV-2? Ever Placed on ECMO? Yes No Not tested for COVID-19 CVID-19 Specific Treatment (s) Orug, Dosage, Route Date Initiated Yes (specify): No Check all that apply) Check all that apply) Drug, Dosage, Route Date Initiated Corradiovasc. disease Hypertension Asthma	Intubated		Positive	Indeterminate			,
□ Hospitalized, non-ICU □ Date Discharged (if previously hospitalized) □ Deceased □ Date Intubated (if applies) □ Positive (if ever intubated) □ Indeterminate □ Negative □ Positive □ Positive □ Negative □ Indeterminate □ Positive □ Negative □ Date of Smell □ Loss of taste Nausea Status History □ Other	Not Intubated	(if ever hospitalized)	Result: Negative	Pending			
□ Not Hospitalized (if previously hospitalized) □ Othong i fest nume □ Diarchae □ Deceased □ Date Intubated □ Positive □ Indeterminate □ Positive □ Pending □ Status History □ Other □ Other □ Other □ Date of first symptom onset □ Date of first symptom onset Ever Hospitalized? □ Yes No □ Positive □ Indeterminate □ Date of first symptom onset Ever InCU? □ Yes No □ Positive □ Indeterminate □ Positive □ Pending □ ver Placed on ECMO? □ Yes No □ Not tested for COVID-19 Travel to or reside in an area with sustained, ongoing, community transmission of SARS-CoV-2? □ Yes No Clinical or Radiologic Evidence of Pneumonia (check all that apply) Clinical or Radiologic Evidence of ARDS (check all that apply) □ Drug, Dosage, Route □ Date Initiated □ Other □ No □ Drug, Dosage, Route □ Date Initiated □ Date of Coronic Kidney of Grases □ No Chronic Conditions (Check all that apply)	Hospitalized, non-ICU	Date Discharged	Serology Test Name				
Deceased	Not Hospitalized	(if previously hospitalized)				Abdominal pain	
If applies) Other intubated) Status History Ever Hospitalized? Yes ICUP Yes Ever Intubated? Yes Ever Intubated? Yes Ever Placed on ECMO? Yes Clinical or Radiologic Clinical or Radiologic Evidence of Pneumonia Check all that apply) Check all that apply) Drug, Dosage, Route Date Initiated 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 Not tested for COVID-19 Covidence of Pneumonia Clinical or Radiologic Clinical or Radiologic Evidence of ARDS Orug, Dosage, Route Date Initiated Orug, Dosage, Route Date Initiated Cardiovasc. disease Outher diagnosis or etailong in the test of the transmission on the test of the transmission on the test of the transmission on the test of thest of the test of the test of the test of th		Date Intubated	Pocult:			Thromboses (e.g. str	oke, DVT, PE)
Ever Hospitalized? Yes No Ever Hospitalized? Yes No Ever InCU? Yes No Ever Intubated? Yes No Ever Placed on ECMO? Yes No Clinical or Radiologic Clinical or Radiologic Clinical or Radiologic Clinical or Radiologic Ever kall that apply) Check all that apply) Drug, Dosage, Route Date Initiated					Other (specify):		
Ever Hospitalized? Yes No Ever in ICU? Yes No Ever Intubated? Yes No Ever Intubated? Yes No Ever Placed on ECMO? Yes No Clinical or Radiologic Clinical or Radiologic Clinical or Radiologic Evidence of Pneumonia Check all that apply) Check all that apply)	Status History		Other		Date of first symptom onset		
Ever in ICU? Yes No Negative Pending Ever Intubated? Yes No Ever Placed on ECMO? Yes No Clinical or Radiologic Clinical or Radiologic Clinical or Radiologic Clinical or Radiologic Ever All that apply) Clinical or Radiologic Clinical or Radiologic Clinical or Radiologic Evidence of Pneumonia Check all that apply) Drug, Dosage, Route Date Initiated	Ever Hospitalized?	Yes 🗌 No	Positive Desitive	Indeterminate			bing, community
Ever Placed on ECMO? Yes No Respiratory Complications Clinical or Radiologic Clinical or Radiologic Clinical or Radiologic Evidence of Pneumonia Check all that apply) Check all that apply) Check all that apply) Drug, Dosage, Route Date Initiated Other diagnosis or etiology for respiratory condition? Yes No Chincal or Radiologic Clinical or Radiologic Clinical or Radiologic No Evidence of Pneumonia Check all that apply) Drug, Dosage, Route Date Initiated None Other diagnosis or etiology for respiratory condition? Yes (specify): No Check all that apply) Drug, Dosage, Route Date Initiated Cardiovasc. disease Hypertension Asthma	Ever in ICU?			Pending			
Ever Placed on ECMO? Yes No Respiratory Complications Clinical or Radiologic Clinical or Radiologic Evidence of Pneumonia Clinical or Radiologic Drug, Dosage, Route Date Initiated (check all that apply) Drug, Dosage, Route Date Initiated Cardiovasc. disease Hypertension Asthma			Not tested for COVID-19				
Respiratory Complications Chronic Conditions Clinical or Radiologic Clinical or Radiologic Evidence of Pneumonia Check all that apply) (check all that apply) Drug, Dosage, Route Drug, Dosage, Route Date Initiated Chronic Conditions (Check all that apply) Diabetes Chronic Kideev disease Hypertension Chronic kideev disease Chronic kideev disease	Ever Placed on ECMO? Yes No		COVID-19 Specific Treatm	ent (s)	-		_
Clinical or Radiologic Clinical or Radiologic Evidence of Pneumonia Evidence of ARDS (check all that apply) Drug, Dosage, Route Date Initiated Cardiovasc. disease Hypertension Asthma Chronic liver disease Chronic liver disease	Respiratory Complications		COTID TO Opecine Incula	<u>ent (0)</u>		itions (Check all that	
(check all that apply) (check all that apply) Chronic kidney disease Chronic liver disease	0		Drug Dosage Route	Date Initiated			
			Drug, Dobuge, Route	Date milated	Cardiovasc. disease	Hypertension	Asthma
None Drug, Dosage, Route Date Initiated				Date Initiated	Chronic lung disease	Chronic kidney disease	Chronic liver disease
Clinical Clinical Stroke Neurological/ Cancer					Stroke		Cancer
Radiologic Radiologic Drug, Dosage, Route Date Initiated Immunocompromised Obesity	Radiologic	Radiologic	Drug Dosage Route	Date Initiated	Immunocompromised	Obesity	Current smoker
Imaging performed (check all that apply)	Imaging performed (check all that apply)		Diug, Dosage, Noute Date initiated		Former smoker	Former smoker Current e-cigarette or vape use	
Chest X-Ray Date Performed Additional Remarks Other (specify):	Chest X-Ray	Date Performed	Additional Remarks		Other (specify):		
Chest CT Scan Date Performed	Chest CT Scan	Date Performed					
Other Chest Imaging Study Date Performed Date Chest Imaging Study	Other Chest Imaging Study	/ Date Performed					