COVID-19 Confidential Morbidity Report

IMMEDIATELY report *Any* Suspected *Case* associated *with Vulnerable Populations** and ***ALL Lab-positive Cases*** to Santa Cruz County Public Health, Communicable Disease Unit

PATIENT INFORMATION

Patient Name: Last, First, MI	**Date of Birth** (mm/dd/yyyy)	Age	**Gender**	Medical Record Number (MRN)

Ethnicity *(check* one*)*: ☐ Hispanic/Latino ☐ NOT Hispanic/Latino ☐ Unknown **Preferred language**: ☐ English ☐ Spanish ☐ Other:_____

Race *(check* all *that apply)*: ☐ White ☐ Black/African Amer. ☐ Asian ☐ Amer. Indian/Alaskan Native ☐ Native Hawaii./Pacific Isl. ☐ Other:_____

Address: Number, Street, Apt #	City	State	ZIP

Able to isolate in own room? ☐ Yes ☐ No ☐ Unknown	**Primary Phone**	Alternative Phone	**Email**

Job Title: _____ *Also check if:* ☐ Healthcare Worker ☐ First Responder (EMT/paramedic/fire/police) ☐ Teacher

Employer/Workplace: _____ ***Last DATE at work**: _____ "Essential worker?" ☐ Yes ☐ No

Vulnerable Population assessment*: Patient currently… ☐ ***Works* and/or ☐ ***Resides*** in the setting(s) below. ***If no concerns**, tick here:* ☐

☐ Skilled nursing facility ☐ Residential facility (ass'td liv.) ☐ Hosp-based resid. facility (long-term acute care) ☐ Group Home / Board and Care

☐ Dorm ☐ Homeless shelter ☐ Mental health, alcohol, or drug treatment facility ☐ Federal correctional facility ☐ State correct'l facility ☐ Jail

☐ Dialysis Center ☐ School ☐ Childcare **Specify Facility/Org NAME**: _____ **Phone**_____

Any o**ther concern** about COVID-19 transmission or social services needed (*e.g. crowded housing*)? _____

CLINICAL STATUS OF PATIENT

Is the patient isolating?	Ever hospitalized for COVID-19?	Ever admitted to ICU for COVID-19?	Did the patient die?
☐ N ☐ Y, location:_____	☐ No ☐ Y, dates: _____--_____	☐ No ☐ Y, dates: _____--_____	☐ No ☐ Y, date:_____

Check **all symptoms** exhibited/reported. ***DATE of *first* COVID-19 symptom**:_____ Have symptoms *resolved*? ☐ No ☐ Y, date:_____

☐ **NONE**	☐ Fever (>100.4F or 38C)	☐ Runny nose	☐ Chills or Rigors (shaking)	☐ Abdominal pain
☐ Cough	☐ Subjective (felt) Fever	☐ Headache	☐ Diarrhea	☐ Loss of smell or taste
☐ Shortness of breath	☐ Sore throat	☐ Muscle aches	☐ Vomiting or nausea	☐ Other, Specify: _____

Severe Acute Lower Respiratory Illness: ☐ Pneumonia **or** ☐ Acute Resp. Distress Synd. (ARDS) *If done: Chest x-ray/CT results:* _____

Pre-existing medical conditions (check all that apply):

☐ **NONE**	☐ Pregnant (EDD: _____)	☐ Diabetes	☐ Chronic Lung Disease	☐ Immunocompromised	
☐ High blood pressure	☐ Current Smoker/ E-cig/ Vape	☐ Chronic Kidney Dis.	☐ Cardiovascular/Heart Dis.	☐ Cancer	☐ Asthma
☐ Obesity	☐ Former Smoker	☐ Chronic Liver Dis.	☐ Neurologic Disability	☐ Other, Specify: _____	

LABORATORY RESULTS *(to be filled by Provider)*

Type of specimen(s) collected: ☐ NP ☐ OP ☐ Other, specify:_____	**Date of Test/Collection**	Result (***Attach lab report***)	Performing lab name

MEDICAL PROVIDER CONTACT

Physician / Infection Preventionist Name	**Healthcare** Organization/Facility Name	**Today's date**

Direct Phone Number	E-mail Address	Fax Number

Optional: How was this patient MOST LIKELY exposed to COVID 19? *Please help us characterize our local epidemic.*

☐ **A. Close contact*** to a lab-confirmed case: ☐ No ☐ Y, date exposed:_____ *Name & DOB of case:*_____

Type of contact: ☐ Household member ☐ Another individual ☐ Healthcare setting ☐ Workplace ☐ School

The term "close contact" applies to all household members, intimate contacts, caregivers, and individuals with any of the following exposures to a person infectious with COVID-19: a) Presence within 6 feet of the person for more than 15 minutes b) Unprotected contact with the person's body fluids and/or secretions.

☐ **B. Group** gathering: ☐ Religious service ☐ Protest/ rally/ demonstration ☐ Friend/family gathering ☐ Other:_____

☐ **C.** Most likely exposed in the **general Community** (i.e., patient has no known exposure to another case and did not travel to an affected area)

☐ **D. Travel** to an area with community transmission of COVID-19 within 14 days prior to symptom onset:

City/County/State/Country: _____ *Dates of Travel:* _____--_____

☐ **E.** Unknown / Not asked

COVID 19 Vaccination History

Received one or more doses of COVID-19 vaccine? ☐ Yes ☐ No

Type of Vaccine (i.e. Pfizer, Moderna, etc.): _____ Date of Dose 1:_____ Date of Dose 2:_____

IMMEDIATELY send COMPLETED form to the Communicable Disease Unit (CDU). FAX: (831) 454-5049 or SECURE Email: HSACD@santacruzcounty.us *ONLY for VULNERABLE Populations, also call CDU: (831) 454-4114.*