

# CONFIDENTIAL MORBIDITY REPORT

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

<b>DISEASE BEING REPORTED: COVID-19</b>			<b>Please write all dates as (mm/dd/yyyy)</b>		
<b>Patient Name - Last Name</b>		<b>First Name</b>		<b>MI</b>	
<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>			
		Years	Months	Days	
<b>Current Gender Identity</b>		<b>Sexual Orientation</b>			
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans male / transman <input type="checkbox"/> Trans female / transwoman <input type="checkbox"/> Genderqueer or non-binary <input type="checkbox"/> Identity not listed (specify): _____ <input type="checkbox"/> Declined to answer		Heterosexual or straight Bisexual Gay, lesbian, or same gender loving Orientation not listed (specify): _____ Questioning / unsure / client doesn't know Declined to answer			
<b>Sex Assigned at Birth</b>		<b>Gender(s) of sex partners (check all that apply)</b>			
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to answer		Male Female Trans male / transman Trans female / transwoman Genderqueer or non-binary Identity not listed (specify): _____ Declined to answer			
<b>Pregnant?</b>					
Yes    No    Unknown If Yes, Est. Delivery Date: _____					
<b>Congregate setting (check if applies)</b>					
Staff    Resident    Unknown Assisted Living Facility    Skilled Nursing Facility    Shelter Correctional Facility    Hospital-Based Facility    Clinic Other (specify): _____					
<b>Name, City of Congregate Setting(s) (if applies):</b>					
<b>Reporting Health Care Provider</b>			<b>Reporting Health Care Facility</b>		
<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>		

**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)**

**Occupation or Job Title**  
 Healthcare worker    In healthcare setting

**Housing Status**  
 Stable    Unstable    Unknown

**REPORT TO:**

(Obtain additional forms from your local health department.)

*Continued on next page.*

