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 | ***First Name*** | ***MI***

Home Address: Number, Street | ***Apt./Unit No.***

City | ***State*** | ***ZIP Code***

Home Telephone Number | ***Cell Telephone Number*** | ***Work Telephone Number***

Email Address | ***Country of Birth***

Primary Language ☐ English ☐ Spanish ☐ Other: _____

Birth Date *(mm/dd/yyyy)* | ***Age*** ☐ Years ☐ Months ☐ Days

Gender: ☐ Male ☐ Female ☐ M to F ☐ F to M ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown *EDD*

Gender(s) of sex partners (check all that apply):
☐ Male ☐ Female ☐ M to F ☐ F to M ☐ Unknown ☐ Declined to state

Congregate setting *(check if applies)*
☐ Staff ☐ Resident ☐ Unknown
☐ Assisted Living Facility ☐ Skilled Nursing Facility ☐ Shelter
☐ Correctional Facility ☐ Hospital-Based Facility ☐ Clinic
☐ Other *(specify)*

What is the patient's sexual orientation?
☐ Heterosexual ☐ Gay/Lesbian/Homosexual ☐ Bisexual ☐ Other ☐ Unknown ☐ Declined to state

Name,City of Congregate Setting(s) *(if applies):*

Occupation or Job Title:
☐ Healthcare Worker ☐ In Healthcare Setting

Housing Status
☐ Stable ☐ Unstable ☐ Unknown

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 ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Thai ☐ Vietnamese ☐ Other *(specify)*: _____
☐ Pacific Islander *(check all that apply)*
☐ Native Hawaiian ☐ Guamanian ☐ Samoan ☐ Other *(specify)*: _____
☐ White
☐ Other *(specify)*: _____ ☐ Unknown

Close contact with a laboratory confirmed COVID-19 case?
☐ Yes ☐ No ☐ Unknown **Additional Contact Details** *(if applies)*
☐ Household contact
☐ Community contact
☐ Any healthcare contact
☐ Workplace contact

Reporting Health Care Provider | ***Reporting Health Care Facility***

Address: Number, Street | ***Suite/Unit No.***

City | ***State*** | ***ZIP Code***

Telephone Number | ***Fax Number***

Email Address: | ***Date Submitted***

REPORT TO:
CITY OF BERKELEY
Health, Housing & Community Services
CD/STD CONTROL
830 UNIVERSITY AVE 2nd Floor
BERKELEY CA 94710
TEL: (510) 981-5300
FAX: (510) 981-5345

(Obtain additional forms from your local health department.)

Laboratory Name | ***City*** | ***State*** | ***ZIP Code***

COVID-19: Hospitalization Status and Diagnostic Testing

Diagnosis Date:

Status at Time of Report
☐ Hospitalized, ICU
☐ Intubated
☐ Not Intubated
☐ Hospitalized, non-ICU
☐ Not Hospitalized
☐ Deceased
Date of Death *(if applies)*

Complete dates where applies
Date Hospitalized (if ever hospitalized)
Date Discharged (if previously hospitalized)
Date Intubated (if ever intubated)

Status History

Ever Hospitalized?	☐ Yes	☐ No
Ever in ICU?	☐ Yes	☐ No
Ever Intubated?	☐ Yes	☐ No
Ever Placed on ECMO?	☐ Yes	☐ No

Respiratory Complications

Clinical or Radiologic Evidence of Pneumonia *(check all that apply)*
☐ None
☐ Clinical
☐ Radiologic

Clinical or Radiologic Evidence of ARDS *(check all that apply)*
☐ None
☐ Clinical
☐ Radiologic

Imaging performed *(check all that apply)*
☐ *Chest X-Ray* *Date Performed*
☐ *Chest CT Scan* *Date Performed*
☐ *Other Chest Imaging Study* *Date Performed*

COVID-19 Testing (Complete all that apply)

☐ **PCR swab (NP and/or OP)**
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

☐ **Serology** **Test Name** _____
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

☐ **Other** _____
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

☐ ***Not tested for COVID-19***

COVID-19 Specific Treatment (s)

Drug, Dosage, Route | Date Initiated
Drug, Dosage, Route | Date Initiated
Drug, Dosage, Route | Date Initiated

Additional Remarks

Clinical Information

COVID-19 Symptoms (Check all that apply)

☐ None	☐ Fever >100.4F, 38C	☐ Subjective fever
☐ Chills	☐ Rigors	☐ Runny nose
☐ Sore throat	☐ Cough	☐ Shortness of Breath
☐ Difficulty breathing	☐ Muscle aches	☐ Headache
☐ Loss of smell	☐ Loss of taste	☐ Nausea
☐ Vomiting	☐ Abdominal pain	☐ Diarrhea
☐ Dermatologic finding	☐ Thromboses (e.g. stroke, DVT, PE)	

☐ 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 ☐ Unknown *If yes, location(s):* _____

Other diagnosis or etiology for respiratory condition?
☐ Yes *(specify)*: _____ ☐ No

Chronic Conditions (Check all that apply)

☐ None	☐ Unknown	☐ Diabetes
☐ Cardiovasc. disease	☐ Hypertension	☐ Asthma
☐ Chronic lung disease	☐ Chronic kidney disease	☐ Chronic liver disease
☐ Stroke	☐ Neurological/ neuro-developemental	☐ Cancer
☐ Immunocompromised	☐ Obesity	☐ Current smoker
☐ Former smoker	☐ Current e-cigarette or vape use	

☐ Other *(specify)*: _____