

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	Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown Race (check all that apply) <input type="checkbox"/> African-American/Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian (check all that apply) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Hmong <input type="checkbox"/> Thai <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Pacific Islander (check all that apply) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> White <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown
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 <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
Birth Date (mm/dd/yyyy)		Age _____ Years _____ Months _____ Days			
Current Gender Identity <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		Sexual Orientation Heterosexual or straight Bisexual Gay, lesbian, or same gender loving Orientation not listed (specify): _____ Questioning / unsure / client doesn't know Declined to answer			
Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to answer		Gender(s) of sex partners (check all that apply) Male Female Trans male / transman Trans female / transwoman Genderqueer or non-binary Identity not listed (specify): _____ Declined to answer			
Pregnant? Yes No Unknown If Yes, Est. Delivery Date: _____					
Congregate setting (check if applies) <input type="checkbox"/> Staff <input type="checkbox"/> Resident <input type="checkbox"/> Unknown <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Shelter <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Hospital-Based Facility <input type="checkbox"/> Clinic Other (specify): _____					
Occupation or Job Title <input type="checkbox"/> Healthcare worker <input type="checkbox"/> In healthcare setting					
Housing Status <input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Unknown					
REPORT TO:					
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		
Laboratory Name		City	State	ZIP Code	

(Obtain additional forms from your local health department.)

Continued on next page.

