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

Current Gender Identity
- ☐ Male
- ☐ Female
- ☐ Trans male / transman
- ☐ Trans female / transwoman
- ☐ Genderqueer or non-binary
- ☐ Identity not listed (specify):_____
- ☐ Declined to answer

Sex Assigned at Birth
☐ Male ☐ Female ☐ Declined to answer

Pregnant?
☐ Yes ☐ No ☐ Unknown

If Yes, Est. Delivery Date: _____

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

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

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)*

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

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

Occupation or Job Title
☐ Healthcare worker ☐ In healthcare setting

Housing Status
☐ Stable ☐ Unstable ☐ Unknown

Reporting Health Care Provider
Vivian Carlton, PA-C

Reporting Health Care Facility
Coastal Family Urgent Care

Address: Number, Street
6260 El Camino Real

Suite/Unit No.
101

City
Carlsbad

State
CA

ZIP Code
92009

Telephone Number
(760)448-6650

Fax Number
(760)448-6647

Email Address:
covid@coastalfamilyuc.com

Date Submitted

REPORT TO:

COUNTY OF SAN DIEGO EPIDEMIOLOGY
Fax (858) 715-6458
Phone (619) 692-8499

Please include information about the test kit that was used and the specimen collection date.

(Obtain additional forms from your local health department.)

Laboratory Name
Coastal Family Urgent Care

City
Carlsbad

State
CA

ZIP Code
92009

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COVID-19: Hospitalization Status and Diagnostic Testing

Diagnosis Date:

Status at Time of Report

Complete dates where applies

- ☐ Hospitalized, ICU
  - ☐ Intubated
  - ☐ Not Intubated
- ☐ Hospitalized, non-ICU
- ☐ Not Hospitalized
- ☐ Deceased

Date of Death *(if 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** Antigen Swab (NP)
  Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
- ☐ ***Not tested for COVID-19***

COVID-19 Specific Treatment (s)

Drug, Dosage, Route	Date Initiated

Additional Remarks

CareStart COVID-19 Antigen Test - Rapid Diagnostic Test for the Detection of SARS-CoV-2 Antigen

MFD:_____ LOT:_____ EXP:_____

Clinical Information

COVID-19 Symptoms (Check all that apply)

- ☐ None
- ☐ Chills
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Loss of smell
- ☐ Vomiting
- ☐ Dermatologic finding
- ☐ Fever >100.4F, 38C
- ☐ Rigors
- ☐ Cough
- ☐ Muscle aches
- ☐ Loss of taste
- ☐ Abdominal pain
- ☐ Thromboses (e.g. stroke, DVT, PE)
- ☐ Subjective fever
- ☐ Runny nose
- ☐ Shortness of Breath
- ☐ Headache
- ☐ Nausea
- ☐ Diarrhea
- ☐ 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
- ☐ Cardiovasc. disease
- ☐ Chronic lung disease
- ☐ Stroke
- ☐ Immunocompromised
- ☐ Former smoker
- ☐ Unknown
- ☐ Hypertension
- ☐ Chronic kidney disease
- ☐ Neurological/ neuro-developemental
- ☐ Obesity
- ☐ Current e-cigarette or vape use
- ☐ Diabetes
- ☐ Asthma
- ☐ Chronic liver disease
- ☐ Cancer
- ☐ Current smoker
- ☐ Other *(specify)*: _____