

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	
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) Staff Resident Unknown Assisted Living Facility Skilled Nursing Facility Shelter Correctional Facility Hospital-Based Facility Clinic Other (specify): _____					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	
Name, City of Congregate Setting(s) (if applies):					Additional Contact Details (if applies)	
Reporting Health Care Provider		Reporting Health Care Facility			Occupation or Job Title Healthcare worker In healthcare setting	
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.

