Confidential Morbidity Report- LTCF/SNF/RCFE

Disease Being Reported: ☐Laboratory Confirmed COVID-19 ☐ Suspected COVD-19	
Reporting facility:	
Submitter's Name:	Submitter's Role at Facility:
Address:	
Telephone Number:	Email:

Patient Information			
Last Name:		First Name:	MI:
Gender:	DOB:	Date of Death (if applicable):	
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown			
Race: ☐ American Indian or Alaska Native ☐Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐white ☐Other ☐Unknown			
Date of Admission:		Admission Source: ☐Home ☐Acute Care Hospital ☐Other LTCF/SNF	
Housing Status: ☐Private room ☐one roommate ☐two or more roommates			
Clinical History			
Is patient symptomatic? ☐ Yes ☐ NO If yes,		Date of onset of symptoms: _____	
Mark all that apply:			
☐None ☐Cough ☐Shortness of breath ☐Runny nose ☐Sore Throat	☐muscle aches ☐Fever >100.4F ☐Subjective Fever ☐Chills ☐Headache	☐Vomiting or nausea ☐Abdominal pain ☐Diarrhea	
Date Patient Isolated: Date of Specimen Collection: Date of Diagnosis:		Control Measures Implemented (Check all that apply) ☐Droplet Precautions ☐Contact Precautions ☐None	
Testing Facility/Lab:			
Was Patient Hospitalized for this illness: ☐ Yes ☐No			
Name of Hospital:		Ambulance Transport Provider:	
Date of Hospital Admission:		Date of Hospital Discharge:	
Comorbid Conditions (Mark all that Apply)			
☐Cardiovascular disease ☐Hypertension ☐Diabetes ☐Chronic liver disease ☐Chronic renal disease ☐Immunocompromised ☐Neurologic/neurodevelopmental		☐Asthma ☐Chronic Pulmonary Disease ☐Former Smoker ☐Other:_____ ☐Unknown ☐None	