Santa Clara County COVID-19 Case Report Form (*For instructions see* "Reporting COVID-19 Cases")

Send via secure email (coronavirus@phd.sccgov.org) or secure fax (408-224-7046)

Today's date:_____ **Healthcare Provider Name**:_____ **Provider phone**:_____

Clinic/Hospital Name:_____

COVID-19 confirmed case home and work information

Patient last name:_____ **Patient first name:** _____

Date of birth: _____ **Primary language**: _____ **MRN:**_____

Race: ( ) American Indian/Alaskan Native ( ) Asian ( ) Black/African American ( ) White
( ) Native Hawaiian or other Pacific Islander ( ) Other ( ) Reported Race: _____ ( ) Unknown

Ethnicity: ( ) Hispanic ( ) Non-Hispanic ( ) Unknown

Current Gender identity: ( ) Male ( ) Female ( ) Trans male/Transman ( ) Trans female/Transwoman
( ) Genderqueer or non-binary ( ) Identity not listed ( ) Declined to answer ( ) Unknown

Sex assigned at birth: ( ) Male ( ) Female ( ) Declined to answer ( ) Unknown

Sexual orientation: ( ) Heterosexual or straight ( ) Bisexual ( ) Gay, lesbian, or same gender loving ( ) Orientation not listed
( ) Questioning/unsure/patient doesn't know ( ) Declined to answer ( ) Unknown

Housing: ( ) Stable housing ( ) Shelter ( ) Homeless ( ) Jail ( ) Long-term care facility ( ) Dormitory ( ) Other/ unknown

Work/Live in congregate setting? **Yes*** No/ unknown ***If yes, is person:** ( ) Resident ( ) Staff ( ) Unknown
For Congregate Setting (name & type): _____

Home address: _____ **City**:_____ **State**:_____ **Zip**: _____

Cell phone #: _____ **Occupation**:_____

Work and location (Name and/or address, please list all):
_____

_____

Clinical Status

Date of positive COVID19 test: _____ **MIS-C (Multisystem Inflammatory Syndrome in Children)** ( ) **Yes** ( ) No

Was case ever symptomatic? ( ) Yes ( ) No **Date of symptom onset** (if known)**:** _____

Specify symptoms:

	Fever > 100.4F (38c)	Subjective Fever	Chills	Rigors
Runny nose (rhinorrhea)	Sore throat	Cough	Shortness of breath / difficulty breathing)	Muscle aches (myalgia)
Headache	Loss of smell	Loss of taste	Nausea	Vomiting
Abdominal pain	Diarrhea	Dermatologic Finding	Thromboses (e.g. stroke, DVT, PE)	
Other				

Did the patient die? ( ) No ( ) **Yes*** ( ) unknown *If yes, date of death: _____ **Pregnant:** No Yes

Hospitalization: ( ) No ( ) **Yes*** ( ) Unknown *If yes, fill in details below about hospitalization **Hospital Admit Date:** _____

Patient in ICU? ( ) No ( ) Yes ( ) Unknown **Additional Comment:**
Patient intubated? ( ) No ( ) Yes ( ) Unknown
Patient on ECMO? ( ) No ( ) Yes ( ) Unknown

Comorbidities?

None	Unknown	Diabetes	Cardiovascular	Hypertension
Asthma	Chronic Lung Disease	Chronic Kidney Disease	Chronic Liver Disease	Stroke
Cancer	Immuno-compromised	Obesity	Current smoker	Other

If Other, specify

Other Health Risks

Former Smoker Current e-cig/vape use Neurologic/neuro-Developmental conditions:_____

Travel: None Domestic International Location(s)/Date(s): _____

Post-Vaccine Case

Was the case fully vaccinated (≥ 14 days following receipt of the second dose in a 2-dose series, or ≥14 days following receipt of one dose of a single-dose vaccine)? No Yes* Unknown

***If yes, fill in details below:**

Completed a 2 dose vaccine series? Name of vaccine _____ Date of first dose_____ Date of second dose_____

Completed a single dose vaccine? Name of vaccine _____ Date of single dose_____

Contacts

Did patient have close contact with a lab confirmed COVID-19 case? No Yes Unknown

If yes, type of contact: Household Community contact **Any healthcare contact***

If healthcare contact, specify: Patient Visitor Healthcare worker

If healthcare contact, specify healthcare facility location: _____

I did not elicit close contacts. Below is the contact information for the patient's next of kin.
The close contacts I was able to elicit are listed below.

☐ I have already contacted them. ☐ I did not contact them.

Next of Kin: Name_____ **Phone**_____

Close Contact #1:

Last Name:_____ **First Name:**_____ **Date of Last Exposure:** _____

DOB:_____**Phone Number:**_____**Household Contact:** Yes No **Notified:** Yes No

Close Contact #2:

Last Name:_____ **First Name:**_____ **Date of Last Exposure:** _____

DOB:_____**Phone Number:**_____**Household Contact:** Yes No **Notified:** Yes No

Close Contact #3:

Last Name:_____ **First Name:**_____ **Date of Last Exposure:** _____

DOB:_____**Phone Number:**_____**Household Contact:** Yes No **Notified:** Yes No

Close Contact #4:

Last Name:_____ **First Name:**_____ **Date of Last Exposure:** _____

DOB:_____**Phone Number:**_____**Household Contact:** Yes No **Notified:** Yes No

Close Contact #5:

Last Name:_____ **First Name:**_____ **Date of Last Exposure:** _____

DOB:_____**Phone Number:**_____**Household Contact:** Yes No **Notified:** Yes No

Close Contact #6:

Last Name:_____ **First Name:**_____ **Date of Last Exposure:** _____

DOB:_____**Phone Number:**_____ **Household Contact:** Yes No **Notified:** Yes No

Clear Form