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

Patient intubated? ◯ No ◯ Yes Unknown

Patient on ECMO? No Yes Unknown

Additional Comment: ◯

Was the patient hospitalized *for* COVID-19 illness?* No Yes Unknown

**Providers should use their best judgment to determine whether the patient was hospitalized in an inpatient bed for symptoms clinically compatible with COVID-19, and not explained by an alternate diagnosis.*

Comorbidities?

None Unknown Hypertension Cancer Obesity Stroke Diabetes Asthma Immunocompromised Other, specify:
Chronic Lung Disease Current Smoker Chronic Liver Disease Chronic Kidney Disease Cardiovascular

Other Health Risks

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

Travel: ◯ None ◯ Domestic ◯ International   Location(s)/Date(s): ______________________

COVID-19 Vaccination History

Has the case received any vaccine dose(s) against COVID-19? ◯ **Yes*** ◯ No ◯ Unknown

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

◯ Dose 1: Name of vaccine ____________ Date Received ________ Purpose

◯ Dose 2: Name of vaccine ____________ Date Received ________ Purpose

◯ Dose 3: Name of vaccine ____________ Date Received ________ Purpose

◯ Dose 4: Name of vaccine ____________ Date Received ________ Purpose

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