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 Choose one

◯ Dose 2: Name of vaccine _____ Date Received _____ Purpose Choose one

◯ Dose 3: Name of vaccine _____ Date Received _____ Purpose Choose one

◯ Dose 4: Name of vaccine _____ Date Received _____ Purpose Choose one

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: _____

Next of Kin: Name _____ **Phone** _____

Note: We no longer request that you supply names of contacts exposed to this case. Please provide the case patient with recommendation for isolation and quarantine of close contacts found on sccstayhome.org.

Clear Form