

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

Patient intubated? No Yes Unknown Comment:

Patient on ECMO? No Yes Unknown

Was the patient hospitalized for COVID-19 illness?* No Yes Unknown
**Providers may use their best judgment to determine whether the patient was hospitalized in an inpatient bed for symptoms clinically compatible with COVID-19, 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): _____

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