

Respiratory Virus Death Report Form

Required Information



SEND COMPLETED FORM TO THE ACUTE COMMUNICABLE DISEASE CONTROL PROGRAM BY SECURE EMAIL to COVIDdeath@ph.lacounty.gov.

DATE OF REPORT		CMR# (internal use only)
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REPORTING FACILITY INFORMATION

DISEASE REPORTED (check all that apply)	<input type="checkbox"/> COVID-19 <input type="checkbox"/> Influenza <input type="checkbox"/> Respiratory Syncytial Virus <input type="checkbox"/> Other: _____
LAB-CONFIRMED CASE OR PUI?	<input type="checkbox"/> LAB-CONFIRMED CASE (If checked, please send lab slip(s), COVID and/or Influenza, with Death Report Form) <input type="checkbox"/> PUI (Person Under Investigation)
PROVIDER NAME (Last, First, MI)	
FACILITY NAME	
PROVIDER Phone Number & Email	

PATIENT INFORMATION

NAME (Last, First, MI)	
DATE OF BIRTH (MM/DD/YYYY)	
DATE OF DEATH (MM/DD/YYYY)	
GENDER IDENTITY <i>(Select one option)</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male/Trans Man <input type="checkbox"/> Transgender Female/Trans Woman <input type="checkbox"/> Gender Non-Binary/Non-Conforming <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prefer not to answer
SEX AT BIRTH	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary or X <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prefer not to answer
SEXUAL ORIENTATION	<input type="checkbox"/> Gay or Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Not sure <input type="checkbox"/> Something else: _____ <input type="checkbox"/> Don't understand the question <input type="checkbox"/> Prefer not to answer
RACE/ETHNICITY <i>(Check all that apply)</i>	<input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latinx/Spanish origin <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prefer not to answer
PLACE OF RESIDENCE AT DISEASE ONSET	Address: _____ City: _____ State: _____ Zip Code: _____ Address Type: <input type="checkbox"/> Residential <input type="checkbox"/> Skilled nursing/Long-term care/Assisted living resident <input type="checkbox"/> Shelter <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Homeless If non-residential, Facility/Shelter name(s): _____ If COVID-19 positive, facility notified of COVID-19 positive status? <input type="checkbox"/> Yes: Date of notification: _____ <input type="checkbox"/> No: Why not? _____
OCCUPATION <i>(Check all that apply)</i>	<input type="checkbox"/> Health Care Worker <input type="checkbox"/> First Responder (fire, police, EMT) <input type="checkbox"/> Education Professional <input type="checkbox"/> Other Occupation: _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown
HOSPITALIZATION DETAILS	Patient admitted? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, ER/ED visit? <input type="checkbox"/> Yes <input type="checkbox"/> No Hospital name: _____ MRN: _____ Date of admission: _____ In ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date ICU admission: _____ ICU discharge: _____ Intubated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date intubation: _____ Date extubation: _____
SYMPTOMS	Onset date: _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown Symptoms: <input type="checkbox"/> Fever >100.4F (38C) <input type="checkbox"/> Subjective Fever <input type="checkbox"/> Chills <input type="checkbox"/> Cough <input type="checkbox"/> Sore throat <input type="checkbox"/> Runny nose (rhinorrhea) <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Headache <input type="checkbox"/> Diarrhea <input type="checkbox"/> Muscle aches <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Other: _____

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COMORBIDITIES <i>(Please specify disease name in the notes section)</i>	<input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Hypertension <input type="checkbox"/> Cardiovascular disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Obese <input type="checkbox"/> Chronic Pulmonary Disease <input type="checkbox"/> Active Tuberculosis <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Renal Disease <input type="checkbox"/> Chronic Liver Disease <input type="checkbox"/> Neurologic/neurodevelopmental condition <input type="checkbox"/> Dementia <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> History of Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Immunocompromised (e.g., CA, AIDS, HIV, Organ Transplant, or immunosuppressive treatments for chronic condition) <input type="checkbox"/> Current Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Other (including specified disease names from categories above): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

PREGNANCY STATUS	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A If yes, estimated due date: _____
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VACCINATION HISTORY <i>If vaccinated, please send medical record (facesheet, H&P, ID consult, death/discharge summary) with Death Report Form</i>	Influenza (vaccinated this season) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, Dose date: _____
	COVID-19 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, Dose #1 date: _____ Manufacturer: _____ Dose #2 date: _____ Manufacturer: _____ Dose #3 date: _____ Manufacturer: _____ Dose #4 date: _____ Manufacturer: _____

LABORATORY INFORMATION

INFLUENZA TYPE A and/or B <i>(During 30 days before death)</i> <i>If positive, please send lab slip with Death Report Form</i>	Specimen collection Date: _____ <input type="checkbox"/> NOT TESTED <input type="checkbox"/> Unknown Performing Lab Name: _____ Test type: <input type="checkbox"/> PCR/NAAT <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> IFA/DFA <input type="checkbox"/> Viral Culture Result: Influenza A: <input type="checkbox"/> (H1) pdm09 <input type="checkbox"/> (H3) <input type="checkbox"/> Lineage Unknown Influenza B: <input type="checkbox"/> Yamagata <input type="checkbox"/> Victoria <input type="checkbox"/> Lineage Unknown <input type="checkbox"/> Negative

COVID-19 <i>If positive, please send lab slip with Death Report Form</i>	Specimen collection Date: _____ <input type="checkbox"/> NOT TESTED <input type="checkbox"/> Unknown Performing Lab Name: _____ Specimen Type: <input type="checkbox"/> NP swab <input type="checkbox"/> OP swab <input type="checkbox"/> Nasal <input type="checkbox"/> Saliva <input type="checkbox"/> Other: _____ Test type: <input type="checkbox"/> PCR/NAAT <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> Other: _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown

TREATMENT INFORMATION

INFLUENZA	Antiviral Start Date: _____	Antiviral End Date: _____
Tx: Oseltamivir	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tx: Zanamivir <input type="checkbox"/> Yes <input type="checkbox"/> No
Tx: Peramivir	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tx: Baloxavir <input type="checkbox"/> Yes <input type="checkbox"/> No

COVID-19		
Tx: Remdesivir	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tx: Ritonavir <input type="checkbox"/> Yes <input type="checkbox"/> No
Tx: Steroids	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tx: Tocilizumab <input type="checkbox"/> Yes <input type="checkbox"/> No

NEXT OF KIN INFORMATION (COVID-19 ONLY)

HAS THE FAMILY BEEN NOTIFIED OF DEATH & COVID (+) STATUS?	<input type="checkbox"/> Yes: Date death notification: _____ Date COVID notification: _____
	<input type="checkbox"/> No: Why not? _____
PLEASE PROVIDE NEXT OF KIN CONTACT INFORMATION	Name: _____ Relationship: _____ Phone No: _____ Email Address: _____

NOTES