



Required Information

DATE OF REPORT	VCMR# (internal use only)	
----------------	---------------------------	--

REPORTING FACILITY INFORMATION

PROVIDER NAME (Last, First, MI)	
FACILITY NAME	
PROVIDER PHONE NUMBER	
PROVIDER EMAIL ADDRESS	
LAB-CONFIRMED CASE OR PUI?	<input type="checkbox"/> LAB-CONFIRMED CASE <input type="checkbox"/> PUI (Person Under Investigation)

PATIENT INFORMATION

NAME (Last, First, MI)	
DATE OF BIRTH	
GENDER	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____
NAME OF HOSPITAL (if different from reporting facility name above)	
MEDICAL RECORD NUMBER	
DATE OF ADMISSION	
WAS PATIENT IN ICU (Y/N)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date of ICU Admission	
WAS PATIENT INTUBATED (Y/N)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date of intubation	
Date of extubation (if applicable)	
CO-MORBIDITIES?	
ANY OTHER VIRUSES +	
DATE OF DEATH	

TREATMENT INFORMATION

Tx: Remdesivir (Y/N)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tx: Tocilizumab(Y/N)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tx: Hydroxychloroquine(Y/N)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tx: Steroids (Y/N)	<input type="checkbox"/> Yes <input type="checkbox"/> No

ADDITIONAL NOTES

Send this completed form to the Communicable Disease Control Program within 24 hours of receiving positive results: Fax to 562.570.4374 or Secure Email to LBEpi@longbeach.gov