

Respiratory Virus Death Report Form

Required Information



DATE OF REPORT		CalREDIE ID (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 (Select one option)	<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"/> 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"/> Other: _____ <input type="checkbox"/> Don't understand the question <input type="checkbox"/> Prefer not to answer
RACE/ETHNICITY (Check all that apply)	<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"/> N/A Yes: Date of notification: _____ No: Why not? _____
OCCUPATION (Check all that apply)	<input type="checkbox"/> Health Care Worker <input type="checkbox"/> First Responder (fire, police, emergency) <input type="checkbox"/> Education <input type="checkbox"/> 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	Yes, Onset date: _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown <u>Symptoms:</u> <input type="checkbox"/> Fever >100.4F (38C) <input type="checkbox"/> Subjective Fever <input type="checkbox"/> Chills <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Sore throat <input type="checkbox"/> Runny nose (rhinorrhea) <input type="checkbox"/> Headache <input type="checkbox"/> Muscle aches <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other: _____
COMORBIDITIES (Please specify disease name in the notes section)	<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"/> Current Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Immunocompromised (e.g., CA, AIDS, HIV, Organ Transplant, or immunosuppressive treatments for chronic condition) <input type="checkbox"/> Other (including specified disease names from categories above): _____
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: _____
VACCINATION HISTORY	Influenza (vaccinated this season) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, Dose date: _____

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VACCINATION HISTORY	COVID-19: Yes No Unknown If yes, Dose #1 date: _____ Manufacturer: _____ Dose #2 date: _____ Manufacturer: _____ Dose #3 date: _____ Manufacturer: _____ Dose #4 date: _____ Manufacturer: _____
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LABORATORY INFORMATION

INFLUENZA TYPE A and/or B (During 30 days before death) If positive, please send lab slip with Death Report Form	Specimen collection Date: _____ NOT TESTED Unknown Performing Lab Name: _____ Test type: PCR/NAAT Rapid Antigen IFA/DFA Viral Culture Result: Influenza A: (H1) pdm09 (H3) Lineage Unknown Negative Influenza B: Yamagata Victoria Lineage Unknown
COVID-19 If positive, please send lab slip with Death Report Form	Specimen collection Date: _____ NOT TESTED Unknown Performing Lab Name: _____ Specimen Type: NP swab OP swab Nasal Saliva Other: _____ Test type: PCR/NAAT Rapid Antigen Other: _____ Result: Positive Negative Unknown

TREATMENT INFORMATION

INFLUENZA	Antiviral Start Date: _____ Antiviral End Date: _____					
Tx: Oseltamivir	<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; text-align: center;">Yes</td> <td style="width: 25%; text-align: center;">No</td> <td style="width: 25%; background-color: #cccccc; text-align: center;">Tx: Zanamivir</td> <td style="width: 25%; text-align: center;">Yes</td> <td style="width: 25%; text-align: center;">No</td> </tr> </table>	Yes	No	Tx: Zanamivir	Yes	No
Yes	No	Tx: Zanamivir	Yes	No		
Tx: Peramivir	<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; text-align: center;">Yes</td> <td style="width: 25%; text-align: center;">No</td> <td style="width: 25%; background-color: #cccccc; text-align: center;">Tx: Baloxa</td> <td style="width: 25%; text-align: center;">Yes</td> <td style="width: 25%; text-align: center;">No</td> </tr> </table>	Yes	No	Tx: Baloxa	Yes	No
Yes	No	Tx: Baloxa	Yes	No		

COVID-19	Antiviral Start Date: _____ Antiviral End Date: _____					
Tx: Remdesivir	<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; text-align: center;">Yes</td> <td style="width: 25%; text-align: center;">No</td> <td style="width: 25%; background-color: #cccccc; text-align: center;">Tx: Molnupiravir</td> <td style="width: 25%; text-align: center;">Yes</td> <td style="width: 25%; text-align: center;">No</td> </tr> </table>	Yes	No	Tx: Molnupiravir	Yes	No
Yes	No	Tx: Molnupiravir	Yes	No		
Tx: Nirmatrelvir/ritonavir	<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; text-align: center;">Yes</td> <td style="width: 25%; text-align: center;">No</td> <td style="width: 25%; background-color: #cccccc; text-align: center;">Tx: Other</td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>	Yes	No	Tx: Other		
Yes	No	Tx: Other				
Monoclonal antibodies:	Sotrovimab Bebtelovimab NONE UNKOWN OTHER _____					

NEXT OF KIN INFORMATION (COVID-19 ONLY)

HAS THE FAMILY BEEN NOTIFIED OF DEATH & COVID (+) STATUS?	Yes: Date death Notification _____ No : Why Not? _____
PLEASE PROVIDE NEXT OF KIN CONTACT INFORMATION	Name: _____ Relationship: _____ Phone No: _____ Email Address: _____

ADDITIONAL NOTES

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