



Required Information

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

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

PATIENT INFORMATION

NAME (Last, First, MI)	
DATE OF BIRTH	
GENDER	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> 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="radio"/> Yes <input type="radio"/> No
If yes, date of ICU Admission	
WAS PATIENT INTUBATED (Y/N)?	<input type="radio"/> Yes <input type="radio"/> No
If yes, date of intubation	
Date of extubation (if applicable)	
CO-MORBIDITIES?	
ANY OTHER VIRUSES +	
DATE OF DEATH	
RACE	<input type="radio"/> Hispanic or Latino <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Asian <input type="radio"/> Black or African American <input type="radio"/> Native Hawaiian or Other Pacific Islander <input type="radio"/> Other <input type="radio"/> Unknown <input type="radio"/> White

TREATMENT INFORMATION

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

VACCINATION HISTORY

Received one or more doses of COVID-19 vaccine	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Date of Dose 1	Date of Dose 2 Type of vaccine <input type="radio"/> Pfizer <input type="radio"/> Moderna <input type="radio"/> Other

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