County of Los Angeles Public Health
Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212
Los Angeles, CA 90012
213-240-7941 (phone), 213-482-4856 (facsimile)
publichealth.lacounty.gov/acd/

# Coronavirus (COVID-19) Death Report Form

## Required Information

Print Form

| DATE OF REPORT | | CMR# (internal use only) | |
|---|---|---|---|

### REPORTING FACILITY INFORMATION

| | |
|---|---|
| PROVIDER NAME (Last, First, MI) | |
| FACILITY NAME | |
| PROVIDER PHONE NUMBER | |
| PROVIDER EMAIL ADDRESS | |
| LAB-CONFIRMED CASE OR PUI? | ☐ COVID-19 LAB-CONFIRMED CASE (If checked, please send lab slip with Death Report Form)<br>☐ COVID-19 PUI (Person Under Investigation) |

### PATIENT INFORMATION

| | |
|---|---|
| NAME (Last, First, MI) | |
| DATE OF BIRTH (MM/DD/YYYY) | |
| GENDER IDENTITY *(Select one option)* | ☐ Male ☐ Female ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman<br>☐ Gender Non-Binary/Non-Conforming ☐ Other: ________________ ☐ Prefer not to state |
| SEX AT BIRTH? | ☐ Male ☐ Female ☐ Non-Binary or X ☐ Other: ____________ ☐ Prefer not to answer |
| SEXUAL ORIENTATION | ☐ Gay or Lesbian ☐ Bisexual ☐ Straight or Heterosexual ☐ Not sure<br>☐ Something else: ________ ☐ Don't understand the question ☐ Prefer not to state |
| RACE/ETHNICITY *(Check all that apply)* | ☐ White ☐ Hispanic/Latinx/Spanish origin ☐ Black/African-American ☐ Asian ☐ Refused<br>☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Other: __________ |
| PLACE OF RESIDENCE **AT DISEASE ONSET** | Address: ______________________________<br>City: ____________________ State: __________ Zip Code: ______________<br>Congregate living? ☐ Yes ☐ No If yes, Facility/Shelter name(s) __________________<br>Facility notified of COVID (+) status? ☐ Yes: Date of notification: ______________<br>☐ No: Why not? ____________________ |
| WAS PATIENT ANY OF THE FOLLOWING *(Check all that apply)* | ☐ Health care worker ☐ First Responder (fire, police, EMT) ☐ Teacher<br>☐ Skilled nursing/Long-term care/Assisted living resident ☐ Homeless<br>☐ Incarcerated ☐ None ☐ Other Occupation: ______________________ |
| HOSPITAL NAME *(if different from above)* | |
| MEDICAL RECORD NUMBER | |
| DATE OF ADMISSION | |
| WAS PATIENT IN ICU (Y/N)? | ☐ Yes ☐ No If yes, Date ICU admission: ____________ ICU discharge: ____________ |
| WAS PATIENT INTUBATED (Y/N)? | ☐ Yes ☐ No If yes, Date intubation: ____________ Date extubation: ____________ |
| CO-MORBIDITIES? | Pregnancy? ☐ Yes ☐ No |
| INFLUENZA TYPE A and/or B TESTING? *(During 30 days before death)* | ☐ Positive ☐ Negative ☐ Not tested If tested, Date specimen collected: __________<br>Test type: ☐ PCR/NAAT ☐ Rapid Antigen ☐ Other:____________________ |
| ANY OTHER VIRUSES + | |
| DATE OF DEATH | |
| HAS THE FAMILY BEEN NOTIFIED OF **DEATH** & **COVID (+) STATUS**? | ☐ Yes: Date death notification: ____________ Date COVID notification: ____________<br>☐ No: Why not? ______________________________ |
| PLEASE PROVIDE NEXT OF KIN CONTACT INFORMATION | Name: ______________________ Relationship: ______________<br>Phone No: ________________ Email Address: ________________ |

### TREATMENT INFORMATION

| | | | |
|---|---|---|---|
| Tx: Remdesivir (Y/N) | ☐ Yes ☐ No | Tx: Tocizilumab (Y/N) | ☐ Yes ☐ No |
| Tx: Hydroxychloroquine (Y/N) | ☐ Yes ☐ No | Tx: Steroids (Y/N) | ☐ Yes ☐ No |

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