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 & Email	
LAB-CONFIRMED CASE OR PUI?	☐ COVID-19 LAB-CONFIRMED CASE (**If checked, please send lab slip with Death Report Form**) ☐ COVID-19 PUI (Person Under Investigation)

PATIENT INFORMATION

NAME (Last, First, MI)	
DATE OF BIRTH (MM/DD/YYYY)	
DATE OF DEATH (MM/DD/YYYY)	
GENDER IDENTITY *(Select one option)*	☐ Male ☐ Female ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman ☐ 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 ☐ 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 ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____
PLACE OF RESIDENCE **AT DISEASE ONSET**	Address: _____ City: _____ State: _____ Zip Code: _____ Congregate living? ☐ Yes ☐ No If yes, Facility/Shelter name(s) _____ Facility notified of COVID (+) status? ☐ Yes: Date of notification: _____ ☐ No: Why not? _____
WAS PATIENT ANY OF THE FOLLOWING: *(Check all that apply)*	☐ Health care worker ☐ First Responder (fire, police, EMT) ☐ Education Professional ☐ Skilled nursing/Long-term care/Assisted living resident ☐ Homeless ☐ Incarcerated ☐ None ☐ Other Occupation: _____
HOSPITALIZATION DETAILS	Patient admitted? ☐ Yes ☐ No If no, ER/ED visit? ☐ Yes ☐ No Hospital name: _____ MRN: _____ Date of admission: _____ In ICU? ☐ Yes ☐ No If yes, Date ICU admission: _____ ICU discharge: _____ Intubated? ☐ 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: _____ Test type: ☐ PCR/NAAT ☐ Rapid Antigen ☐ Other: _____ ***If positive, please send lab slip with Death Report Form***
COVID-19 VACCINATION?	☐ Yes ☐ No ☐ Unk If yes, Dose #1 date: _____ Manufacturer: _____ Dose #2 date: _____ Manufacturer: _____ Dose #3 date: _____ Manufacturer: _____
HAS THE FAMILY BEEN NOTIFIED OF **DEATH** & **COVID (+) STATUS**?	☐ Yes: Date death notification: _____ Date COVID notification: _____ ☐ No: Why not? _____
PLEASE PROVIDE NEXT OF KIN CONTACT INFORMATION	Name: _____ Relationship: _____ 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.