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/

# Respiratory Virus Death Report Form
## Required Information

Print Form

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

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

### REPORTING FACILITY INFORMATION

| | |
|---|---|
| **DISEASE REPORTED (check all that apply)** | ☐ COVID-19 ☐ Influenza ☐ Respiratory Syncytial Virus<br>☐ Other: _____ |
| 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) | |
| WAS THE DEATH COVID-ASSOCIATED? | ☐ Yes ☐ No ☐ Unknown<br>Deaths should be considered COVID-associated if COVID-19:<br>• directly preceded death<br>• initiated the train of morbid events leading directly to death<br>• is a significant condition that contributed to the death |
| 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 answer |
| 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 answer |
| RACE/ETHNICITY *(Check all that apply)* | ☐ White ☐ Hispanic/Latinx/Spanish origin ☐ Black/African American ☐ Asian<br>☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____<br>☐ Prefer not to answer |
| PLACE OF RESIDENCE **AT DISEASE ONSET** | Address: _____<br>City: _____ State: _____ Zip Code: _____<br>Address Type: ☐ Residential ☐ Skilled nursing/Long-term care/Assisted living resident<br>☐ Shelter ☐ Correctional Facility ☐ Homeless<br>If non-residential, Facility/Shelter name(s): _____<br>**If COVID-19 positive**, facility notified of COVID-19 positive status?<br>☐ Yes: Date of notification: _____ ☐ No: Why not? _____ |
| OCCUPATION *(Check all that apply)* | ☐ Health Care Worker ☐ First Responder (fire, police, EMT) ☐ Education Professional<br>☐ Other Occupation: _____<br>☐ None ☐ Unknown |
| HOSPITALIZATION DETAILS | Patient admitted? ☐ Yes ☐ No If no, ER/ED visit? ☐ Yes ☐ No<br>Hospital name: _____ MRN: _____<br>Date of admission: _____<br>In ICU? ☐ Yes ☐ No If yes, Date ICU admission: _____ ICU discharge: _____<br>Intubated? ☐ Yes ☐ No If yes, Date intubation: _____ Date extubation: _____ |
| SYMPTOMS | Onset date: _____ ☐ None ☐ Unknown<br>Symptoms:<br>☐ Fever >100.4F (38C) ☐ Subjective Fever ☐ Chills<br>☐ Cough ☐ Sore throat ☐ Runny nose (rhinorrhea)<br>☐ Shortness of breath ☐ Headache ☐ Diarrhea<br>☐ Muscle aches ☐ Vomiting ☐ Abdominal pain<br>☐ Other: _____ |

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| | |
|---|---|
| COMORBIDITIES<br>*(Please specify disease name in the notes section)* | ☐ None ☐ Unknown<br>☐ Hypertension ☐ Cardiovascular disease ☐ Diabetes ☐ Obese<br>☐ Chronic Pulmonary Disease ☐ Active Tuberculosis ☐ Asthma<br>☐ Chronic Renal Disease ☐ Chronic Liver Disease<br>☐ Neurologic/neurodevelopmental condition ☐ Dementia ☐ Alzheimer's Disease ☐ History of Stroke<br>☐ Cancer ☐ Immunocompromised (e.g., CA, AIDS, HIV, Organ Transplant, or immunosuppressive treatments for chronic condition)<br>☐ Current Smoker ☐ Former Smoker<br>☐ Other (including specified disease names from categories above): |
| PREGNANCY STATUS | Pregnant ☐ Yes ☐ No ☐ Unknown ☐ N/A If yes, estimated due date: _____ |
| VACCINATION HISTORY<br>*If vaccinated, please send medical record (facesheet, H&P, ID consult, death/discharge summary) with Death Report Form* | Influenza (vaccinated this season)<br>☐ Yes ☐ No ☐ Unknown If yes, Dose date: _____ |

## LABORATORY INFORMATION

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

## TREATMENT INFORMATION

| INFLUENZA | Antiviral Start Date: _____ | Antiviral End Date: _____ | |
|---|---|---|---|
| Tx: Oseltamivir | ☐ Yes ☐ No | Tx: Zanamivir | ☐ Yes ☐ No |
| Tx: Peramivir | ☐ Yes ☐ No | Tx: Baloxavir | ☐ Yes ☐ No |

## NOTES