LONG BEACH HEALTH & HUMAN SERVICES
Department of Health & Human Services
2525 Grand Ave, Long Beach, CA 90815
562.570.4302

Respiratory Virus Death Report Form

Required Information

DATE OF REPORT		CalREDIE ID (internal use only)	

REPORTING FACILITY INFORMATION

DISEASE REPORTED (check all that apply)	☐ COVID-19 ☐ Influenza ☐ Respiratory Syncytial Virus ☐ Other:_____
LAB-CONFIRMED CASE OR PUI?	☐ LAB-CONFIRMED CASE (If checked, please send lab slip(s), COVID and/or Influenza, with Death Report Form) ☐ 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)	☐ Male ☐ Female ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman ☐ Gender Non-Binary/Non-Conforming ☐ Other:_____ ☐ Prefer not to answer
SEX AT BIRTH	☐ Male ☐ Female ☐ Other: _____ ☐ Prefer not to answer
SEXUAL ORIENTATION	☐ Gay or Lesbian ☐ Bisexual Straight or Heterosexual ☐ Not sure ☐ Other: _____ ☐ Don't understand the question ☐ Prefer not to answer
RACE/ETHNICITY (Check all that apply)	☐ White ☐ Hispanic/Latinx/Spanish origin ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____ ☐ Prefer not to answer
PLACE OF RESIDENCE AT DISEASE ONSET	Address: _____ City: _____ State: _____ Zip Code: _____ Address Type: ☐ Residential ☐ Skilled nursing/Long-term care/Assisted living resident ☐ Shelter ☐ Correctional Facility ☐ Homeless If non-residential, Facility/Shelter name(s): _____ **If COVID-19 positive**, facility notified of COVID-19 positive status? ◯ N/A ◯ Yes: Date of notification: _____ ◯ No: Why not?
OCCUPATION (Check all that apply)	☐ Health Care Worker ☐ First Responser (fire, police, emergency) ☐ Education ☐ Professional ☐ Other Occupation: _____ ☐ None ☐ Unknown
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:
SYMPTOMS	◯ Yes, Onset date: _____ ◯ None ◯ Unknown Symptoms: ☐ Fever >100.4F (38C) ☐ Subjective Fever ☐ Chills ☐ Shortness of breath ☐ Cough ☐ Sore throat ☐ Runny nose (rhinorrhea) ☐ Headache ☐ Muscle aches ☐ Vomiting ☐ Abdominal pain ☐ Diarrhea ☐ Other: _____
COMORBIDITIES (Please specify disease name in the notes section)	☐ None ☐ Unknown ☐ Hypertension ☐ Cardiovascular disease ☐ Diabetes ☐ Obese ☐ Chronic Pulmonary Disease ☐ Active Tuberculosis ☐ Asthma ☐ Chronic Renal Disease ☐ Chronic Liver Disease ☐ Neurologic/neurodevelopmental condition ☐ Dementia ☐ Alzheimer's Disease ☐ History of Stroke ☐ Cancer ☐ Current Smoker ☐ Former Smoker ☐ Immunocompromised (e.g., CA, AIDS, HIV, Organ Transplant, or immunosuppressive treatments for chronic condition) ☐ Other (including specified disease names from categories above):_____
PREGNANCY STATUS	Pregnant: ◯ Yes ◯ No ◯ Unknown ◯ N/A If yes, estimated due date: _____
VACCINATION HISTORY	**Influenza** (vaccinated this season) ◯ Yes ◯ No ◯ 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: _____

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	☐ Yes ☐ No	Tx: Zanamivir	☐ Yes	☐ No
Tx: Peramivir	☐ Yes ☐ No	Tx: Baloxa	☐ Yes	☐ No

COVID-19	Antiviral Start Date: _____	Antiviral End Date: _____		
Tx: Remdesivir	☐ Yes ☐ No	Tx: Molnupiravir	☐ Yes	☐ No
Tx: Nirmatrelvir/ritonavir	☐ 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