

Ingham County Report of COVID -19 Patient Death *(items in bold are required)*

Patient's Name _____

DOB _____ Date of Death _____

Gender: _____ Admit Date: _____

County of residence _____

City of residence: _____

Hospital / Org.: _____

Location of Death (ED? ICU?) _____

COVID-19 POSITIVE test by:

reporting hospital test date _____

other (name): _____

on (test date) _____

or

COVID-19 SUSPECTED

test pending, test by:

current hospital, test date _____

other (name): _____

on (test date): _____

COVID-19 contact or travel history

Comorbidities

Comments

- Diabetes
- Hypertension
- Heart Disease
- Chronic Kidney Disease

- COPD / Emphysema
- Asthma
- OSA or Sleep Apnea

- Cancer
- HIV
- Transplant Recipient
- Pregnancy
- Other immune problem

- Alcohol Abuse or drug abuse

Date Reported _____

MRN _____

Patient came from *(mark all that apply)*

- Nursing Home
- Residential / Group Home
- Dormitory
- Shelter
- Prison
- Other Group setting:

Name of Residence / Building:

Address _____

Organization Contact name

and role? _____

(_____) _____ -- _____

Who can we call with questions? Name

Role? _____

Phone: (_____) _____ -- _____
cell? office? Other?

Please **fax** medical records including H&P Discharge Summary and any transfer notes to ICHD Communicable Disease Division at - **517-887-4379**. For questions call **517-887-4308**.