Pasdena Public Health Department
1845 N Fair Oaks Avenue
Pasadena, CA 91103
https://www.cityofpasadena.net/public-health/

Provider Report of COVID-19 Laboratory Results

PASADENA PUBLIC HEALTH DEPARTMENT

MEDICAL PROVIDER INFORMATION

Physician/Infection Preventionist Name	Facility Name	
Physician/ Infection Preventionist Pager/Phone number	E-mail Address	Date of Report

PATIENT INFORMATION

Patient Name-Last, First, Middle Initial | Facility name (if not living at home): | Date of Birth | Age

Patient's current gender identity? (select one option/response) ☐ Male ☐ Female ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman ☐ Unknown ☐ Gender Non-Conforming/ Gender Non-Binary ☐ Other _____ ☐ Prefer not to state

Patient's sex at birth? ☐ Male ☐ Female ☐ Non-Binary or ☐ Other: _____ ☐ Unknown ☐ Prefer not to state

Sexual Orientation: Does the patient consider themselves to be…

☐ Gay or Lesbian ☐ Bisexual ☐ Straight or Heterosexual ☐ Not sure ☐ Something else: _____ ☐ Don't understand the question ☐ Prefer not to state ☐ Unknown

Patient's race or ethnicity? (check all that apply) ☐ White ☐ Hispanic/Latino/Spanish origin ☐ Black/African-American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____ ☐ Refused ☐ Unknown

Address- Number, Street, Apt #	City	State	ZIP Code

Primary Phone Number	Alternative Phone Number	Email Address

Patient currently resides in: ☐ Private residence ☐ Hotel ☐ Homeless ☐ Detention facility ☐ Nursing home/long-term healthcare ☐ Residential Care/Assisted Living ☐ School/University dorm ☐ Military base ☐ Shelter ☐ Other: _____

Occupation: ☐ Healthcare Worker: If Hospital: Unit & Floor? _____ ☐ Teacher ☐ First Responder (fire, police, EMT) ☐ Other: _____

CLINICAL INFORMATION

Symptomatic? ☐ Yes ☐ No	If Yes, Date of onset	Hospitalized? ☐ Yes ☐ No	Date of admission	Medical Record Number

Severe Acute Lower Respiratory Illness: (☐ pneumonia **OR** ☐ ARDS): Chest x-ray/CT results: _____

Pre-existing medical conditions (check all that apply):

☐ Pregnancy ☐ Diabetes ☐ Hypertension ☐ Cardiovascular disease ☐ Chronic pulmonary disease ☐ Asthma ☐ Chronic renal disease ☐ Chronic liver disease ☐ Immunocompromised ☐ Neurologic disability ☐ Other: _____

LABORATORY INFORMATION

Specimen type	Test performed	Collection date	Result	Performing lab name
☐ NP swab ☐ OP swab ☐ Nasal ☐ Saliva ☐ Other: _____	☐ PCR/NAAT ☐ Antigen ☐ Other: _____			
☐ NP swab ☐ OP swab ☐ Nasal ☐ Saliva ☐ Other: _____	☐ PCR/NAAT ☐ Antigen ☐ Other: _____			

COVID-19 vaccination? ☐ Yes ☐ No ☐ Unknown If Yes, Dose #1 date: _____ Manufacturer: _____

Dose #2 date: _____ Manufacturer: _____

SEND COMPLETED FORM TO PUBLIC HEALTH NURSING
BY FAX at (626) 744-6115 or SECURE EMAIL TO nursing@cityofpasadena.net