Saginaw County HEALTH DEPARTMENT

Caring experts, advocates & champions. For health. For everyone.

Confidential Report of Suspect or Confirmed COVID-19 Patient Death

Please complete the following fields and Fax it to ***(989) 758-3750***

Reporting Hospital/Organization: _____ Date Reported: _____

Patient First Name: _____ Patient Last Name: _____

Date of Birth: _____ Date of Death: _____

Gender: _____ Admit Date: _____

County of Residence _____ MRN: _____

COVID-19 Confirmed POSITIVE? Yes No

If No, is Patient SUSPECT? Yes No

Patient Came from (mark all that apply)

- ☐ Nursing Home - List Name: _____
- ☐ Private Residence
- ☐ Group Home
- ☐ Dormitory
- ☐ Shelter
- ☐ Prison
- ☐ Other Group Setting specify: _____

Comorbidities (mark all that apply)

- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Chronic Kidney Disease
- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ OSA or Sleep Apnea
- ☐ Cancer
- ☐ HIV
- ☐ Transplant Recipient
- ☐ Pregnancy
- ☐ Other immune problem
- ☐ Alcohol or Dug Use

Race (mark all that apply)

- ☐ Caucasian
- ☐ Black/African American
- ☐ American Indian/Alaskan Native
- ☐ Hawiian/Pacific Islander
- ☐ Asian
- ☐ Unknown
- ☐ Other Please Specify: _____

Ethnicity (mark all that apply)

- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino
- ☐ Arab
- ☐ Non-Arab
- ☐ Unknown

Comments: