



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/

Medical Provider Report of COVID-19 Laboratory Results



****FORM MUST BE TYPED OR THE AUTOMATED SYSTEM
WILL REJECT THE REPORT****

ONLY REPORT POSITIVE PCR/NAAT OR ANTIGEN TESTS
For residents of LA County (excluding Pasadena and Long Beach)

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)		Patient's sex at birth? <input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male/Trans Man <input type="checkbox"/> Transgender Female/Trans Woman <input type="checkbox"/> Gender Non-Binary, Gender Non-Conforming <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prefer not to state		<input type="checkbox"/> Non-Binary or X <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prefer not to answer	
Patient's sexual orientation? (select one option/response)			
<input type="checkbox"/> Gay or Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Not sure <input type="checkbox"/> Something else: _____ <input type="checkbox"/> Don't understand the question <input type="checkbox"/> Prefer not to state			
Patient's race or ethnicity? (check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino/Spanish origin <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian			
<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other: _____ <input type="checkbox"/> Refused			
Address- Number, Street, Apt #		City	State CA
ZIP Code			
Primary Phone Number	Alternative Phone Number	Email Address	
Patient currently resides in: <input type="checkbox"/> Private residence <input type="checkbox"/> Hotel <input type="checkbox"/> Homeless <input type="checkbox"/> Detention facility <input type="checkbox"/> Nursing home/long-term healthcare			
<input type="checkbox"/> Residential Care/Assisted Living <input type="checkbox"/> School/University dorm <input type="checkbox"/> Military base <input type="checkbox"/> Shelter <input type="checkbox"/> Other: _____			
Occupation: <input type="checkbox"/> Healthcare Worker: If Hospital: Unit & Floor? _____ <input type="checkbox"/> Teacher <input type="checkbox"/> First Responder (fire, police, EMT) <input type="checkbox"/> Other: _____			

CLINICAL INFORMATION

Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date of onset	Medical Record Number
Pre-existing medical conditions (check all that apply):		
<input type="checkbox"/> Pregnancy <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Cardiovascular disease <input type="checkbox"/> Chronic pulmonary disease <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic renal disease <input type="checkbox"/> Chronic liver disease <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Neurologic disability <input type="checkbox"/> Other: _____		

LABORATORY INFORMATION

Specimen type	Test performed	Collection date	Result	Performing lab name
<input type="checkbox"/> NP swab <input type="checkbox"/> OP swab <input type="checkbox"/> Nasal <input type="checkbox"/> Saliva <input type="checkbox"/> Other: _____	<input type="checkbox"/> PCR/NAAT <input type="checkbox"/> Antigen <input type="checkbox"/> Other: _____		Positive	
<input type="checkbox"/> NP swab <input type="checkbox"/> OP swab <input type="checkbox"/> Nasal <input type="checkbox"/> Saliva <input type="checkbox"/> Other: _____	<input type="checkbox"/> PCR/NAAT <input type="checkbox"/> Antigen <input type="checkbox"/> Other: _____		Positive	

COVID-19 vaccination? Yes No Unk If Yes, Dose #1 date: _____ Manufacturer: _____
 Dose #2 date: _____ Manufacturer: _____
 Dose #3 date: _____ Manufacturer: _____

**SEND COMPLETED FORM TO THE ACUTE COMMUNICABLE DISEASE CONTROL PROGRAM
BY FAX at (310) 605-4274 or SECURE EMAIL to COVID19@ph.lacounty.gov.**