County of Los Angeles Public Health
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)

☐ Male ☐ Female ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman

☐ Gender Non-Binary, Gender Non-Conforming ☐ Other: _____ ☐ Prefer not to state

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

Patient's sexual orientation? (select one option/response)

☐ Gay or Lesbian ☐ Bisexual ☐ Straight or Heterosexual ☐ Not sure ☐ Something else: _____

☐ Don't understand the question ☐ Prefer not to state

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

Address- Number, Street, Apt #	City	State CA	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	Medical Record Number

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: _____		Positive	
☐ NP swab ☐ OP swab ☐ Nasal ☐ Saliva ☐ Other: _____	☐ PCR/NAAT ☐ Antigen ☐ 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.