COVID-19 Fatal Outcome Notification Form

Please complete all fields

A) PERSON REPORTING – HEALTH CARE PROVIDER INFORMATION

Attending Physician or Nurse:	***FOR PUBLIC HEALTH OFFICE USE ONLY:***
Phone number:	**Service Area:**
Hospital Name and Unit (if applicable):	**Date Received:**
Location:	**Panorama Client ID:**
	Panorama Investigation ID:
	Panorama QA complete: ☐ **Yes** ☐ **No**

B) CLIENT INFORMATION (please complete or affix patient label in the table below)

Last Name:	First Name: and Middle Name:	Alternate Name (Goes by):
DOB: YYYY / MM / DD Age: _____	Health Card Province: _____ Health Card Number (PHN): _____	Gender: ☐ Male ☐ Female ☐ Other ☐ Unknown
Next of Kin: _____ Relationship: _____ Contact phone: _____	Address Type: ☐ No fixed ☐ Postal Address ☐ Primary Home ☐ Temporary ☐ Legal Land Description Mailing (Postal address): Street Address or FN Community (Primary Home):	

C) LABORATORY DETAILS

LAB TEST INFORMATION:

Test type: ☐ PCR **Date specimen collected:** YYYY / MM / DD ☐ Antigen **Date specimen collected:** YYYY / MM / DD

D) RISK FACTORS (check all that apply)

Chronic Medical Condition - Cardiac Disease	☐ **Yes**	☐ No ☐ Not asked ☐ Unknown	**Chronic Medical Condition** – Morbid Obesity	☐ **Yes**	☐ No ☐ Not asked ☐ Unknown
Chronic Medical Condition - Diabetes Mellitus	☐ **Yes**	☐ No ☐ Not asked ☐ Unknown	**Chronic Medical Condition** - Other (Add'l Info)	☐ **Yes**	☐ No ☐ Not asked ☐ Unknown
Chronic Medical Condition - Hypertension	☐ **Yes**	☐ No ☐ Not asked ☐ Unknown	**Immunocompromised** - Related to disease or treatment	☐ **Yes**	☐ No ☐ Not asked ☐ Unknown
Chronic Medical Condition - Lung Disease (does not include asthma)	☐ **Yes**	☐ No ☐ Not asked ☐ Unknown	**Pregnancy**	☐ **Yes**	☐ No ☐ Not asked ☐ Unknown
Special Population –Long Term Care Facility Resident Include the name of the facility	☐ **Yes**	☐ No ☐ Not asked ☐ Unknown			
Special Population – Personal Care Home Resident Include the name of the facility	☐ **Yes**	☐ No ☐ Not asked ☐ Unknown			

E) OUTCOMES

Fatal - Date of Death YYYY / MM / DD How was COVID-19 Related to Cause of Death:

☐ Underlying cause of death
☐ Contributed to but was not underlying cause of death
☐ Unrelated to cause of death

Report completed by:		**Date report completed:** YYYY / MM / DD

Please save a copy for your file and fax to the local public health office.