LE GOUVERNEMENT
DU GRAND-DUCHÉ DE LUXEMBOURG
Ministère de la Santé
Direction de la Santé

COVID-19
Division de l'Inspection Sanitaire
20, rue de Bitbourg
L- 1273 Luxembourg
Tél. : (+352) 247-85650
Fax : (+352) 480323
www.ms.public.lu
inspecteur-sanitaire@ms.etat.lu

COVID-19 mortality surveillance
(meets the requirements of the World Health Organization)

Attention: Form to be used only in the event of death by COVID-19
Important notice: The duly completed, dated and signed form must be sent to the Health Inspection Division at the address given in the header.

This interactive page requires Adobe Acrobat® Reader® version 8.1.3 or higher. The latest version of Adobe Acrobat Reader for all systems (Windows, Mac, etc.) can be downloaded for free on the Adobe Systems Incorporated website.

Input

Fields marked with an * are mandatory

Patient's data

1. Nat. identification number : *(matricule)*
☐ or date of birth if no id number (dd/mm/yyyy) :

Firstname :

Surname : *(maiden name if applicable)*

2. Sex* : ☐ Male ☐ Female ☐ Unknown

Address :

3.a. Date of death (dd/mm/yyyy)* :

3.b. Date of onset of first symptoms (dd/mm/yyyy)* :

4. Was a sample collected for laboratory confirmation of COVID-19 infection?* : ☐ Yes ☐ No ☐ Unknow

a. If yes, date first sample was collected (dd/mm/yyyy) :

b. Laboratory result : ☐ Positive ☐ Negative ☐ Pending ☐ Inconclusive

5. Was patient admitted to hospital?* : ☐ Yes ☐ No ☐ Unknow

If yes, date of admission (dd/mm/yyyy) :

6. Was the patient admitted to an intensive care unit (ICU)?* : ☐ Yes ☐ No ☐ Unkown

7. Did the patient receive mechanical ventilation?* : ☐ Yes ☐ No ☐ Unkown

8. Did the patient receive extracorporeal membrane oxygenation (ECMO)?* : ☐ Yes ☐ No ☐ Unkown
☐ ECMO not available in the treatment hospital

9. Did the patient have a co-infection with another respiratory pathogen* : ☐ Yes ☐ No ☐ Unkown
☐ Not tested

If yes, please specify which pathogen(s) :

10. Cause of death as listed on the death certificate* :

11. Was an autopsy performed?* : ☐ Yes ☐ No ☐ Unknow

If yes, what were the results? :

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12. Did the patient have an underlying condition(s)?* : ☐Yes ☐No ☐Unknow

If yes, please specify which condition(s) from i. to xi. :

i. Asthma, requiring treatment within last 3 years* : ☐Yes ☐No ☐Unknow

ii. Chronic respiratory disease (excluding asthma))* : ☐Yes ☐No ☐Unknow

iii. Chronic cardiovascular disease, including hypertension* : ☐Yes ☐No ☐Unknow

iv. Chronic renal disease* : ☐Yes ☐No ☐Unknow

v. Chronic liver disease* : ☐Yes ☐No ☐Unknow

vi. Chronic neurological or neuromuscular disease* : ☐Yes ☐No ☐Unknow

vii. Diabetes requiring insulin or oral hypoglycaemic* : ☐Yes ☐No ☐Unknow

viii. Obesity* : ☐Yes ☐No ☐Unknow

ix. Immunosuppression (due to disease, including HIV)* : ☐Yes ☐No ☐Unknow

x. Immunosuppression (due to treatment)* : ☐Yes ☐No ☐Unknow

xi. Any other medical condition?* : ☐Yes ☐No ☐Unknow

If other conditions, please indicate which :

13. Was the patient pregnant?* : ☐Yes ☐No ☐Unknow

If pregnant, please specify trimester : ☐1st ☐2nd ☐3rd ☐Unknown

14. Additional comments:

Signature of reporting doctor

Place* :

Date* :

(signature)

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