

## How to Use the OHA COVID-19 Reporting Portal (OCRP)

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You can get this document in other languages, large print, braille, or a format you prefer. Contact the Coronavirus Response and Recovery Unit (CRRU) at 503-979-3377 or email [CRRU@dhsosha.state.or.us](mailto:CRRU@dhsosha.state.or.us). We accept all relay calls, or you can dial 711.

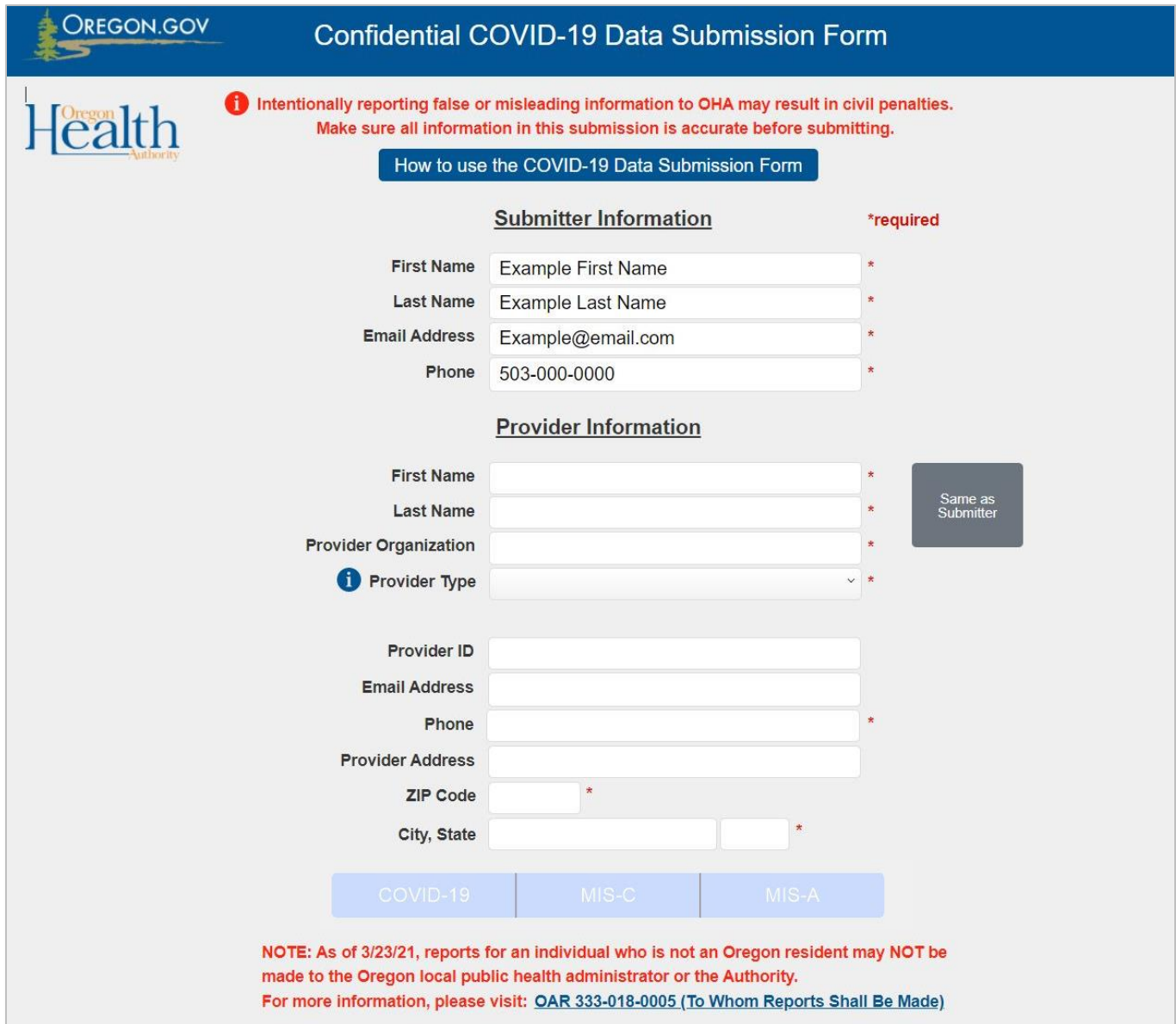
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## How to Use the OHA COVID-19 Reporting Portal (OCRP)


The OHA COVID-19 Reporting Portal (OCRP) is located here: [OHA COVID-19 Reporting Portal](#)  
Other methods to report COVID-19 cases are located here: [The Oregon ELR Project](#)

### Submitter Information

1. Enter in Submitter's **First Name**
2. Enter in Submitter's **Last Name**
3. Enter in Submitter's **Email Address**
4. Enter in Submitter's **Phone**



**OREGON.GOV** Confidential COVID-19 Data Submission Form

 **i** Intentionally reporting false or misleading information to OHA may result in civil penalties.  
Make sure all information in this submission is accurate before submitting.

How to use the COVID-19 Data Submission Form

**Submitter Information** \*required

First Name  \*

Last Name  \*

Email Address  \*

Phone  \*

**Provider Information**

First Name  \*

Last Name  \*

Provider Organization  \*

**i** Provider Type  \*

Provider ID

Email Address

Phone  \*

Provider Address

ZIP Code  \*

City, State   \*

Same as Submitter

COVID-19 MIS-C MIS-A

**NOTE:** As of 3/23/21, reports for an individual who is not an Oregon resident may NOT be made to the Oregon local public health administrator or the Authority.  
For more information, please visit: [OAR 333-018-0005 \(To Whom Reports Shall Be Made\)](#)

**Provider Information**

1. Enter in Provider's **First Name**
2. Enter in Provider's **Last Name**  
**NOTE:** If the submitter and provider is the same, you can use the **Same as Submitter** button.
3. Enter in **Provider Organization**
4. Select the **Provider Type**  
**NOTE:** Click on the white and blue *i* button to see the definitions of each provider type.
5. Enter in **Provider ID**
6. Enter in Provider's **Email Address**
7. Enter in Provider's **Phone**
8. Enter in **Provider's Address**
9. Enter in Provider's **ZIP Code**  
**NOTE:** **City** and **State** will automatically populate based on the **ZIP Code**.
10. If you're entering in COVID-19 information, click on the **COVID-19** button. If you're entering in information regarding Multisystem Inflammatory Syndrome in Children (MIS-C) or Multisystem Inflammatory Syndrome in Adults (MIS-A), click on either the **MIS-C** or **MIS-A** button.

**Provider Information**

First Name

Example First Name

\*

Last Name

Example Last Name

\*

Provider Organization

OHA

\*

i

Provider Type

State Public Health

▼

\*

Provider ID

123456

Email Address

Example@email.com

Phone

503-000-0000

\*

Provider Address

800 NE Oregon St.

ZIP Code

97232

\*

City, State

Portland

OR

\*

Same as Submitter

COVID-19

MIS-C

MIS-A

## Patient Information

1. Enter in Patient's **First Name**
2. Enter in Patient's **Middle Name**
3. Enter in Patient's **Last Name**
4. Enter in Patient's **Date Of Birth**

**NOTE:** If the date of birth is unknown, click the **unknown** checkbox, and enter in the **approximate age**.

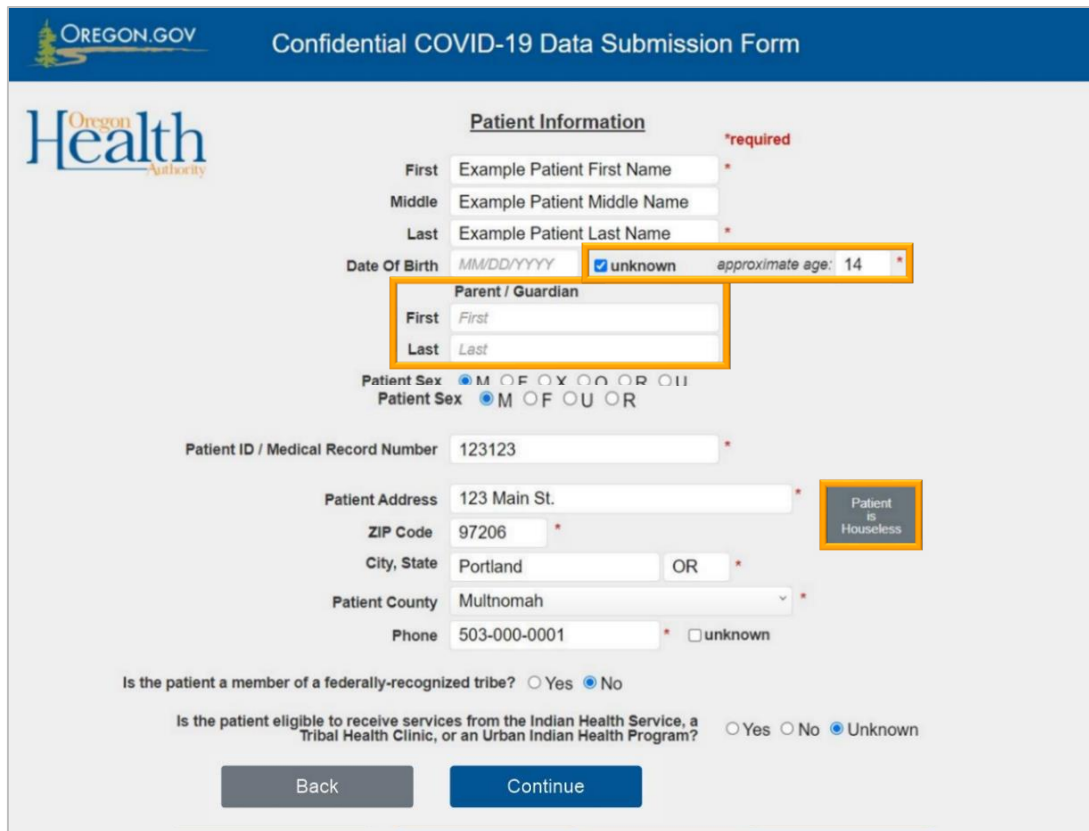
**NOTE:** If the patient is under 15 years old, enter in **Parent / Guardian** information.

5. Select the **Patient's Sex**
6. Enter in **Patient ID / Medical Record Number**
7. Enter in **Patient's Address, ZIP Code, City, State, and County**

**NOTE:** If the patient is houseless, please use the **Patient is Houseless** button.

8. Enter in Patient's **Phone**
9. Select whether the patient is a member of a federally recognized Tribe and/or whether the patient is eligible to receive tribal health services
10. Click on **Continue**

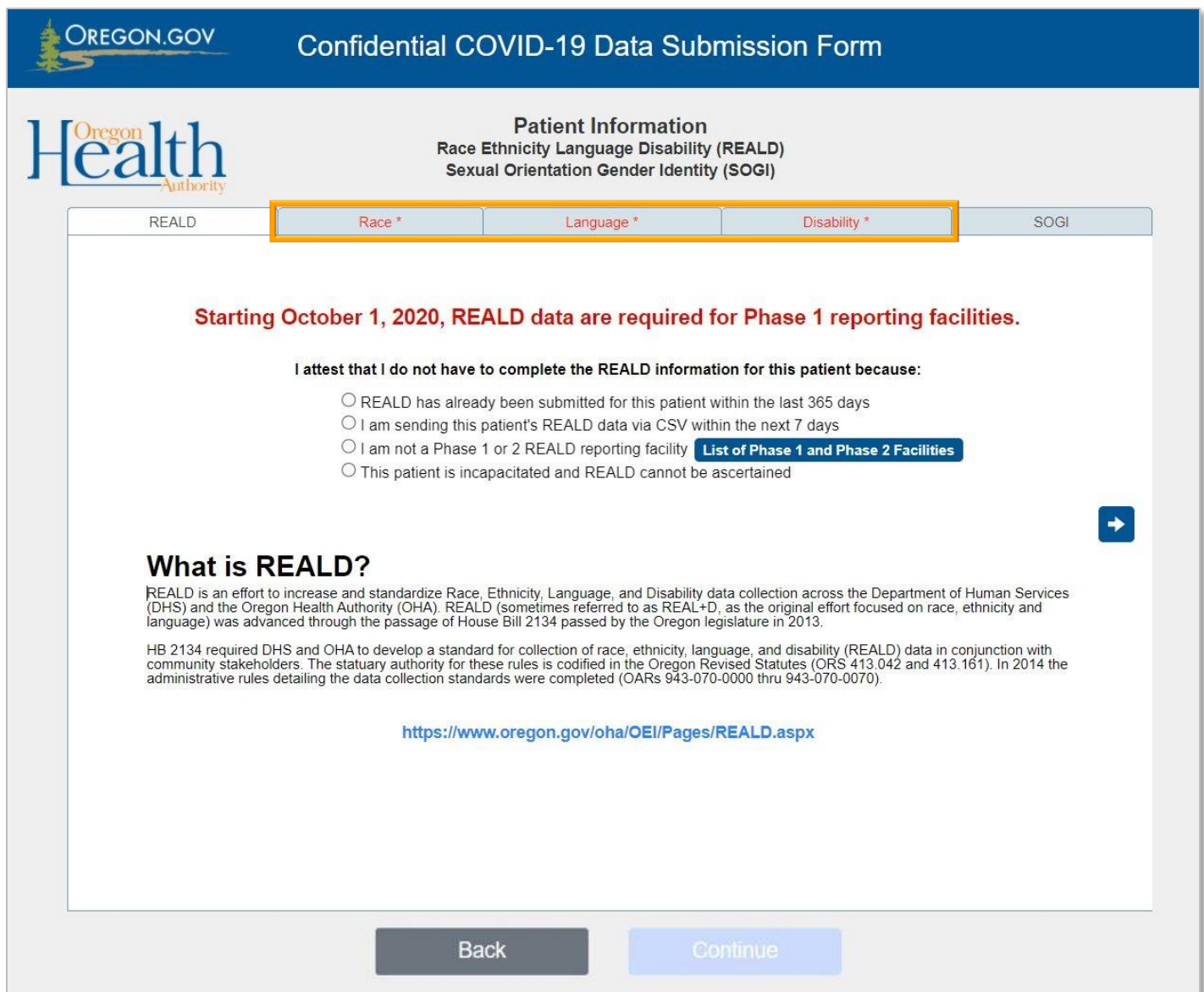
**NOTE:** If you are submitting a MIS-C or MIS-A report, you do not need to complete REAL-D and SOGI. Skip ahead to either [MIS-C](#) or [MIS-A](#).



The screenshot shows the "Confidential COVID-19 Data Submission Form" with the "Patient Information" section highlighted. The form includes fields for First Name, Middle Name, Last Name, Date Of Birth (with a checkbox for "unknown" and an "approximate age" field), Parent / Guardian information (First and Last Name), Patient Sex (radio buttons for M, F, U, R), Patient ID / Medical Record Number, Patient Address, ZIP Code, City, State (dropdown), Patient County (dropdown), and Phone (with an "unknown" checkbox). There are also checkboxes for "Patient is Houseless", "Is the patient a member of a federally-recognized tribe?", and "Is the patient eligible to receive services from the Indian Health Service, a Tribal Health Clinic, or an Urban Indian Health Program?". The "Continue" button is highlighted in blue.

**Race, Ethnicity, Language, and Disability (REAL-D)**

1. If you are exempt from collecting Race, Ethnicity, Language, and Disability (REAL-D) information from this patient, select the reason why and click on **Continue**. Skip ahead to [Clinical Details / Clinical Status / Exposure Risks](#)
2. If none of the selections apply, use the navigation tabs to answer all REAL-D questions  
**NOTE:** All REAL-D questions are required. REAL-D is an effort to increase and standardize data collection of demographic information. This information is used to address health inequities between diverse communities, to ensure that we reach those who are most at risk. Information regarding REAL-D can be found here: [What is REAL-D?](#)
3. Start by clicking on the **Race** tab



The screenshot shows the "Confidential COVID-19 Data Submission Form" from Oregon.gov. The form is titled "Patient Information" and includes sections for "Race Ethnicity Language Disability (REALD)" and "Sexual Orientation Gender Identity (SOGI)". The "REALD" section is highlighted with a blue border. Below the title, there are four tabs: "REALD", "Race \*", "Language \*", and "Disability \*". The "Race \*" tab is selected. The main content area contains a red notice: "Starting October 1, 2020, REALD data are required for Phase 1 reporting facilities." Below this, there is a section titled "I attest that I do not have to complete the REALD information for this patient because:" with four radio button options: "REALD has already been submitted for this patient within the last 365 days", "I am sending this patient's REALD data via CSV within the next 7 days", "I am not a Phase 1 or 2 REALD reporting facility" (with a link to "List of Phase 1 and Phase 2 Facilities"), and "This patient is incapacitated and REALD cannot be ascertained". A blue arrow button is on the right. Below this is a section titled "What is REALD?" with a paragraph explaining the initiative and a link to "https://www.oregon.gov/oha/OEI/Pages/REALD.aspx". At the bottom, there are "Back" and "Continue" buttons.

OREGON.GOV Confidential COVID-19 Data Submission Form

**Patient Information**  
Race Ethnicity Language Disability (REALD)  
Sexual Orientation Gender Identity (SOGI)

REALD Race \* Language \* Disability \* SOGI

**Starting October 1, 2020, REALD data are required for Phase 1 reporting facilities.**

I attest that I do not have to complete the REALD information for this patient because:

- ☐ REALD has already been submitted for this patient within the last 365 days
- ☐ I am sending this patient's REALD data via CSV within the next 7 days
- ☐ I am not a Phase 1 or 2 REALD reporting facility [List of Phase 1 and Phase 2 Facilities](#)
- ☐ This patient is incapacitated and REALD cannot be ascertained

**What is REALD?**

REALD is an effort to increase and standardize Race, Ethnicity, Language, and Disability data collection across the Department of Human Services (DHS) and the Oregon Health Authority (OHA). REALD (sometimes referred to as REAL+D, as the original effort focused on race, ethnicity and language) was advanced through the passage of House Bill 2134 passed by the Oregon legislature in 2013.

HB 2134 required DHS and OHA to develop a standard for collection of race, ethnicity, language, and disability (REALD) data in conjunction with community stakeholders. The statutory authority for these rules is codified in the Oregon Revised Statutes (ORS 413.042 and 413.161). In 2014 the administrative rules detailing the data collection standards were completed (OARs 943-070-0000 thru 943-070-0070).


<https://www.oregon.gov/oha/OEI/Pages/REALD.aspx>


Back Continue



## REAL-D – Race Questions

1. Enter in how the patient identifies their race, ethnicity, tribal affiliation, county of origin or ancestry for question 1
2. Select how the patient describes their racial or ethnic identity for question 2
3. If two or more racial or ethnic identities were selected, select the patient's primary racial or ethnic identity for question 3
4. Click on the **Language** tab


**Confidential COVID-19 Data Submission Form**


**Patient Information**  
 Race Ethnicity Language Disability (REALD)  
 Sexual Orientation Gender Identity (SOGI)

REALD	Race *	Language *	Disability *	SOGI
* 1. How do you identify your <b>race, ethnicity, tribal affiliation, country of origin, or ancestry</b> ? <input type="text" value="Unknown"/> <input type="button" value="Unknown"/> <input type="button" value="Decline"/>				
* 2. Which of the following describes your <b>racial or ethnic identity</b> ? Please check <b>ALL</b> that apply.				
<div> <div> <b>Hispanic or Latino/a/x ?</b> <input type="checkbox"/> Central American  <input type="checkbox"/> Mexican  <input type="checkbox"/> South American  <input type="checkbox"/> Other Hispanic or Latino/a/x         </div> <div> <b>American Indian or Alaska Native ?</b> <input type="checkbox"/> American Indian  <input type="checkbox"/> Alaska Native  <input type="checkbox"/> Canadian Inuit, Metis, or First Nation  <input type="checkbox"/> Indigenous Mexican, Central American, or South American         </div> <div> <b>Asian ?</b> <input type="checkbox"/> Asian Indian  <input type="checkbox"/> Cambodian  <input type="checkbox"/> Chinese  <input type="checkbox"/> Communities of Myanmar  <input type="checkbox"/> Filipino/a  <input type="checkbox"/> Hmong  <input type="checkbox"/> Japanese  <input type="checkbox"/> Korean  <input type="checkbox"/> Laotian  <input type="checkbox"/> South Asian  <input type="checkbox"/> Vietnamese  <input type="checkbox"/> Other Asian         </div> </div> <div> <div> <b>Native Hawaiian or Pacific Islander ?</b> <input type="checkbox"/> CHamoru (Chamorro)  <input type="checkbox"/> Marshallese  <input type="checkbox"/> Communities of the Micronesian Region  <input checked="" type="checkbox"/> Native Hawaiian  <input checked="" type="checkbox"/> Samoan  <input type="checkbox"/> Other Pacific Islander         </div> <div> <b>Black or African American ?</b> <input type="checkbox"/> African American  <input type="checkbox"/> Afro-Caribbean  <input type="checkbox"/> Ethiopian  <input type="checkbox"/> Somali  <input type="checkbox"/> Other African (Black)  <input type="checkbox"/> Other Black         </div> <div> <b>Other Categories</b>  <input type="checkbox"/> Other <input type="text" value="Please specify..."/> </div> </div> <div> <div> <b>White ?</b> <input type="checkbox"/> Eastern European  <input type="checkbox"/> Slavic  <input type="checkbox"/> Western European  <input type="checkbox"/> Other White         </div> <div> <b>Middle Eastern/North African ?</b> <input type="checkbox"/> North African  <input type="checkbox"/> Middle Eastern         </div> </div>				
* 3. If you checked <b>more than one</b> category above, is there <b>one</b> you think of as your <b>primary</b> racial or ethnic identity? <input type="text" value="Samoan"/>				

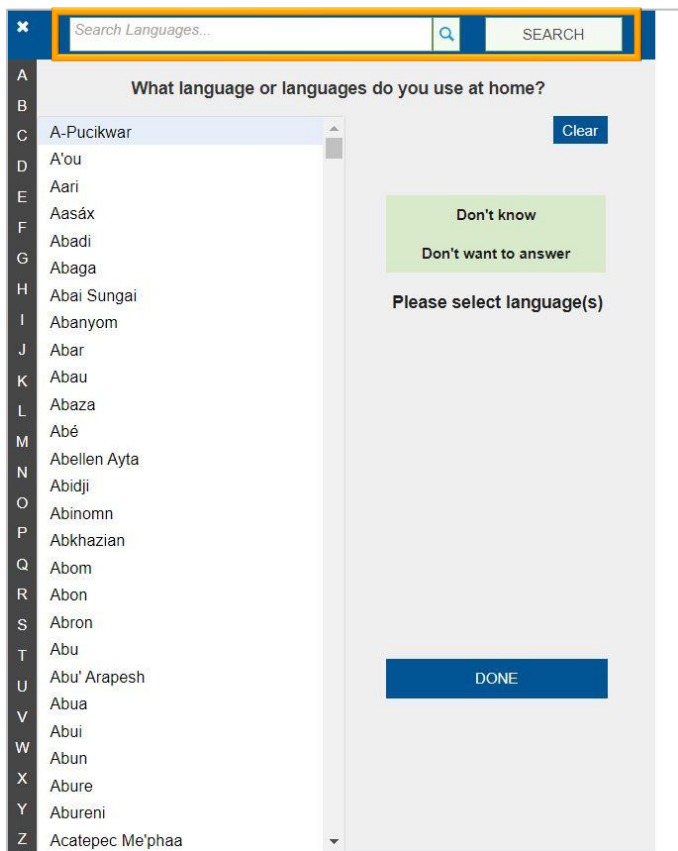
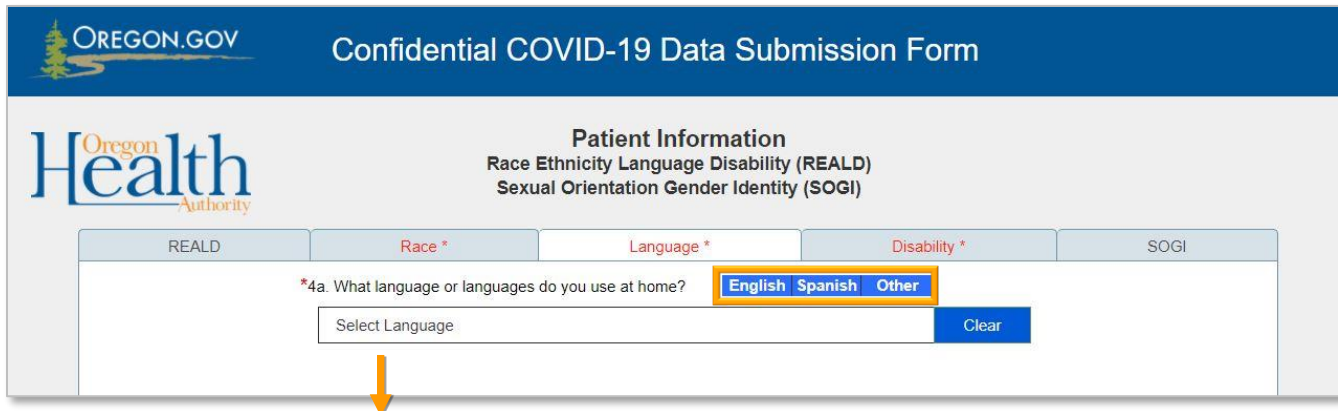
**REAL-D – Language Questions**

1. Select an answer for **What language or languages the patient uses at home?**


**NOTE:** You can select multiple languages for this question.


**NOTE:** If just **English** is selected, you do not need to answer the rest of the Language questions.

**NOTE:** You can use the **English**, **Spanish**, and **Other** buttons to quickly select **English** and/or **Spanish**.



2. Select a language for **In what language do you want us to communicate in person, on the phone, or virtually with you?**  
**NOTE:** You can only select one language for this question.
3. Select a language for **In what language do you want us to write to you?**  
**NOTE:** You can only select one language for this question.
4. Select an answer for **Do you need or want an interpreter for us to communicate with you?**  
**NOTE:** If the patient needs or wants an interpreter, select what type of interpreter is preferred.
5. Select an answer for **How well do you speak English?**
6. Click the **Disability** tab


**Confidential COVID-19 Data Submission Form**



**Patient Information**  
 Race Ethnicity Language Disability (REALD)  
 Sexual Orientation Gender Identity (SOGI)

REALD	Race *	Language *	Disability *	SOGI
<div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 60%;"> <p><b>*4a. What language or languages do you use at home?</b></p> <div style="border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;">English, Spanish</div> <p><b>*4b. In what language do you want us to communicate in person, on the phone, or virtually with you?</b></p> <div style="border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;">Don't know</div> <p><b>*4c. In what language do you want us to write to you?</b></p> <div style="border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;">Don't know</div> <p><b>* 5a. Do you need or want an interpreter for us to communicate with you?</b></p> <p> <input checked="" type="radio"/> Yes           <input type="radio"/> No           <input type="radio"/> Don't know           <input type="radio"/> Don't want to answer         </p> <p><b>* 5b. If you need or want an interpreter, what type of interpreter is preferred?</b></p> <p> <input type="checkbox"/> Spoken language interpreter  <input type="checkbox"/> American Sign Language interpreter  <input type="checkbox"/> Deaf Interpreter for DeafBlind, additional barriers, or both  <input type="checkbox"/> Contact sign language (PSE) interpreter  <input checked="" type="checkbox"/> Other (please list):         </p> <div style="border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;">Unknown</div> <p><b>* 6. How well do you speak English?</b></p> <p> <input type="radio"/> Very Well           <input type="radio"/> Not Well           <input type="radio"/> Don't Know  <input checked="" type="radio"/> Well           <input type="radio"/> Not at all           <input type="radio"/> Don't want to answer         </p> </div> <div style="width: 35%; text-align: right;"> <div style="background-color: #005596; color: white; padding: 2px 5px; margin-bottom: 5px;">English Spanish Other</div> <div style="background-color: #005596; color: white; padding: 2px 5px; margin-bottom: 5px;">Clear</div> <div style="background-color: #005596; color: white; padding: 2px 5px; margin-bottom: 5px;">Clear</div> <div style="background-color: #005596; color: white; padding: 2px 5px; margin-bottom: 5px;">Clear</div> <div style="background-color: #005596; color: white; padding: 2px 5px; margin-bottom: 5px;">Unknown Decline</div> </div> </div>				

Back

Continue

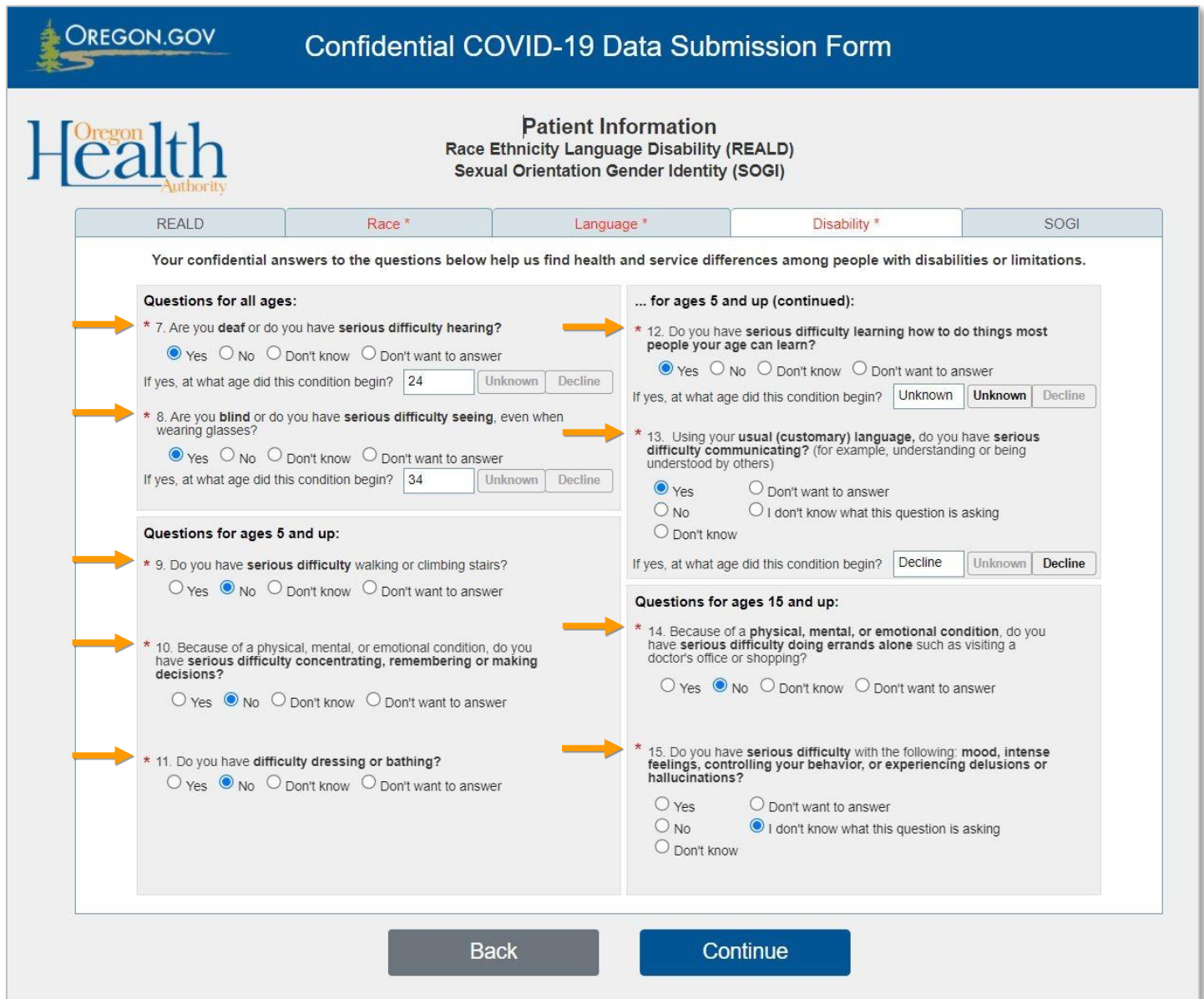


## REAL-D – Disability Questions

1. Answer all disability questions 7-15

**NOTE:** If the patient's age is less than 5 or 15 years old, you do not need to answer the questions for ages 5 and/or 15 years and up.

2. Click on the **SOGI** tab



**OREGON.GOV** Confidential COVID-19 Data Submission Form

**Patient Information**  
Race Ethnicity Language Disability (REALD)  
Sexual Orientation Gender Identity (SOGI)

REALD Race \* Language \* Disability \* SOGI

Your confidential answers to the questions below help us find health and service differences among people with disabilities or limitations.

**Questions for all ages:**

\* 7. Are you **deaf** or do you have **serious difficulty hearing**?  
☒ Yes ☐ No ☐ Don't know ☐ Don't want to answer  
 If yes, at what age did this condition begin? 24 Unknown Decline

\* 8. Are you **blind** or do you have **serious difficulty seeing**, even when wearing glasses?  
☒ Yes ☐ No ☐ Don't know ☐ Don't want to answer  
 If yes, at what age did this condition begin? 34 Unknown Decline

**Questions for ages 5 and up:**

\* 9. Do you have **serious difficulty walking or climbing stairs**?  
☐ Yes ☒ No ☐ Don't know ☐ Don't want to answer

\* 10. Because of a physical, mental, or emotional condition, do you have **serious difficulty concentrating, remembering or making decisions**?  
☐ Yes ☒ No ☐ Don't know ☐ Don't want to answer

\* 11. Do you have **difficulty dressing or bathing**?  
☐ Yes ☒ No ☐ Don't know ☐ Don't want to answer

**... for ages 5 and up (continued):**

\* 12. Do you have **serious difficulty learning how to do things most people your age can learn**?  
☒ Yes ☐ No ☐ Don't know ☐ Don't want to answer  
 If yes, at what age did this condition begin? Unknown Unknown Decline

\* 13. Using your **usual (customary) language**, do you have **serious difficulty communicating**? (for example, understanding or being understood by others)  
☒ Yes ☐ Don't want to answer  
☐ No ☐ I don't know what this question is asking  
☐ Don't know  
 If yes, at what age did this condition begin? Decline Unknown Decline

**Questions for ages 15 and up:**

\* 14. Because of a **physical, mental, or emotional condition**, do you have **serious difficulty doing errands alone** such as visiting a doctor's office or shopping?  
☐ Yes ☒ No ☐ Don't know ☐ Don't want to answer

\* 15. Do you have **serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations**?  
☐ Yes ☐ Don't want to answer  
☐ No ☒ I don't know what this question is asking  
☐ Don't know

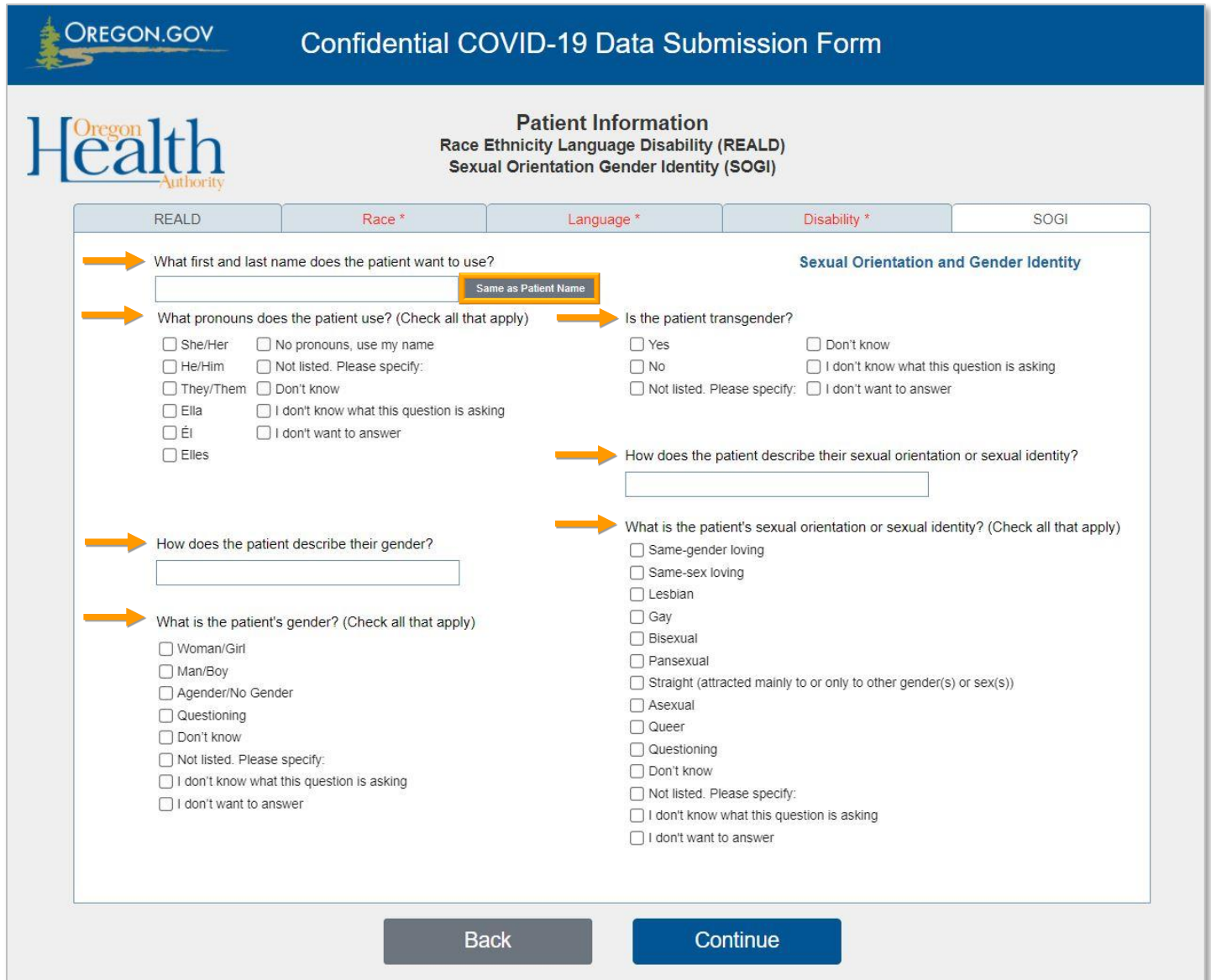
Back Continue

## Sexual Orientation and Gender Identity (SOGI)

1. Answer all 7 SOGI questions

**NOTE:** You can use the **Same as Patient Name** button to populate the patient's name for the question **What first and last name does the patient want to use?**

2. Click on **Continue**



**OREGON.GOV** **Confidential COVID-19 Data Submission Form**


**Patient Information**  
Race Ethnicity Language Disability (REALD)  
Sexual Orientation Gender Identity (SOGI)


REALD	Race *	Language *	Disability *	SOGI
<p><b>What first and last name does the patient want to use?</b></p> <input type="text"/> <b>Same as Patient Name</b>				<p><b>Sexual Orientation and Gender Identity</b></p>
<p><b>What pronouns does the patient use? (Check all that apply)</b></p> <p> <input type="checkbox"/> She/Her    <input type="checkbox"/> No pronouns, use my name  <input type="checkbox"/> He/Him    <input type="checkbox"/> Not listed. Please specify:  <input type="checkbox"/> They/Them    <input type="checkbox"/> Don't know  <input type="checkbox"/> Ella    <input type="checkbox"/> I don't know what this question is asking  <input type="checkbox"/> Él    <input type="checkbox"/> I don't want to answer  <input type="checkbox"/> Elles </p>				<p><b>Is the patient transgender?</b></p> <p> <input type="checkbox"/> Yes    <input type="checkbox"/> Don't know  <input type="checkbox"/> No    <input type="checkbox"/> I don't know what this question is asking  <input type="checkbox"/> Not listed. Please specify:    <input type="checkbox"/> I don't want to answer </p>
<p><b>How does the patient describe their gender?</b></p> <input type="text"/>				<p><b>How does the patient describe their sexual orientation or sexual identity?</b></p> <input type="text"/>
<p><b>What is the patient's gender? (Check all that apply)</b></p> <p> <input type="checkbox"/> Woman/Girl  <input type="checkbox"/> Man/Boy  <input type="checkbox"/> Agender/No Gender  <input type="checkbox"/> Questioning  <input type="checkbox"/> Don't know  <input type="checkbox"/> Not listed. Please specify:  <input type="checkbox"/> I don't know what this question is asking  <input type="checkbox"/> I don't want to answer </p>				<p><b>What is the patient's sexual orientation or sexual identity? (Check all that apply)</b></p> <p> <input type="checkbox"/> Same-gender loving  <input type="checkbox"/> Same-sex loving  <input type="checkbox"/> Lesbian  <input type="checkbox"/> Gay  <input type="checkbox"/> Bisexual  <input type="checkbox"/> Pansexual  <input type="checkbox"/> Straight (attracted mainly to or only to other gender(s) or sex(s))  <input type="checkbox"/> Asexual  <input type="checkbox"/> Queer  <input type="checkbox"/> Questioning  <input type="checkbox"/> Don't know  <input type="checkbox"/> Not listed. Please specify:  <input type="checkbox"/> I don't know what this question is asking  <input type="checkbox"/> I don't want to answer </p>

**Back** **Continue**


**Clinical Details / Clinical Status / Exposure Risks**

1. Select whether the patient has symptoms compatible with COVID-19
2. Enter in **Date of Symptom Onset**
3. Select all symptoms that apply
4. Select **Patient Classification**
5. Enter in the **Facility Name**
6. Select whether the patient has been admitted to a hospital
7. Enter in **Admit Date**
8. Select whether the patient has been admitted to ICU
9. Select whether the patient has died
10. Enter in **Date of Death**
11. Select whether the patient is a close contact of a known case
12. Click on **Continue**




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## Confidential COVID-19 Data Submission Form



### Clinical Details

Does the patient have symptoms compatible with COVID-19? ☒ Yes ☐ No

Date of Symptom Onset  ☒ unknown

#### Symptoms

<input type="checkbox"/> Cough	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Feeling feverish	<input checked="" type="checkbox"/> Muscle pain	<input checked="" type="checkbox"/> Sore throat	<input type="checkbox"/> Nausea
<input type="checkbox"/> Fever >=100.3F	<input type="checkbox"/> Headache	<input type="checkbox"/> Chills	<input type="checkbox"/> Loss of sense of taste	<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Difficulty breathing	<input checked="" type="checkbox"/> Loss of sense of smell	<input type="checkbox"/> Nasal Discharge	

### Clinical Status

**Patient Classification**
☐ Inpatient
 ☐ Healthcare Worker
 ☒ Resides in Congregate Setting
 ☐ Works in Congregate Setting
 ☐ Outpatient
 ☐ Other

Facility Name

Has the patient been admitted to the hospital? ☒ Yes ☐ No

Patient admitted to ICU? ☒ Yes ☐ No


Did the patient die? ☒ Yes ☐ No


### Exposure Risks

Is this patient a close contact of a known case? ☒ Yes ☐ No

**Testing Details**

1. Select the **COVID Test Result**
2. Select the **Test Type**
3. Select whether if it was the patient's first COVID-19 test
4. Enter in **Laboratory Name**
5. Enter in **Specimen Collection Date**
6. Select whether the patient has already been notified of the diagnosis lab result
7. Enter in **Device Identifier**
8. Review all information from all sections and confirm the information is correct and accurate  
**NOTE:** Once you click on **Submit**, you will not be able to edit your submission. Please review your submission first.
9. Click on **Submit**
10. Skip ahead to [Printing the Report for Your Records](#)

Oregon Health Authority

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Confidential COVID-19 Data Submission Form

**Testing Details**  
*\*required*

**\* COVID Test Result**


☒ Positive  
☐ Negative  
☐ No Result/Result Pending  
☐ Clinical or only suspect at this time

**\* Test Type**

☒ PCR  
☐ NAAT  
☐ Antigen  
☐ Antibody

Is this the patient's first COVID-19 Test? ☒ Yes ☐ No ☐ Unknown

Laboratory Name

Specimen Collection Date   \*

Has the patient already been notified of the diagnosis lab result? ☒ Yes ☐ No ☐ Unknown

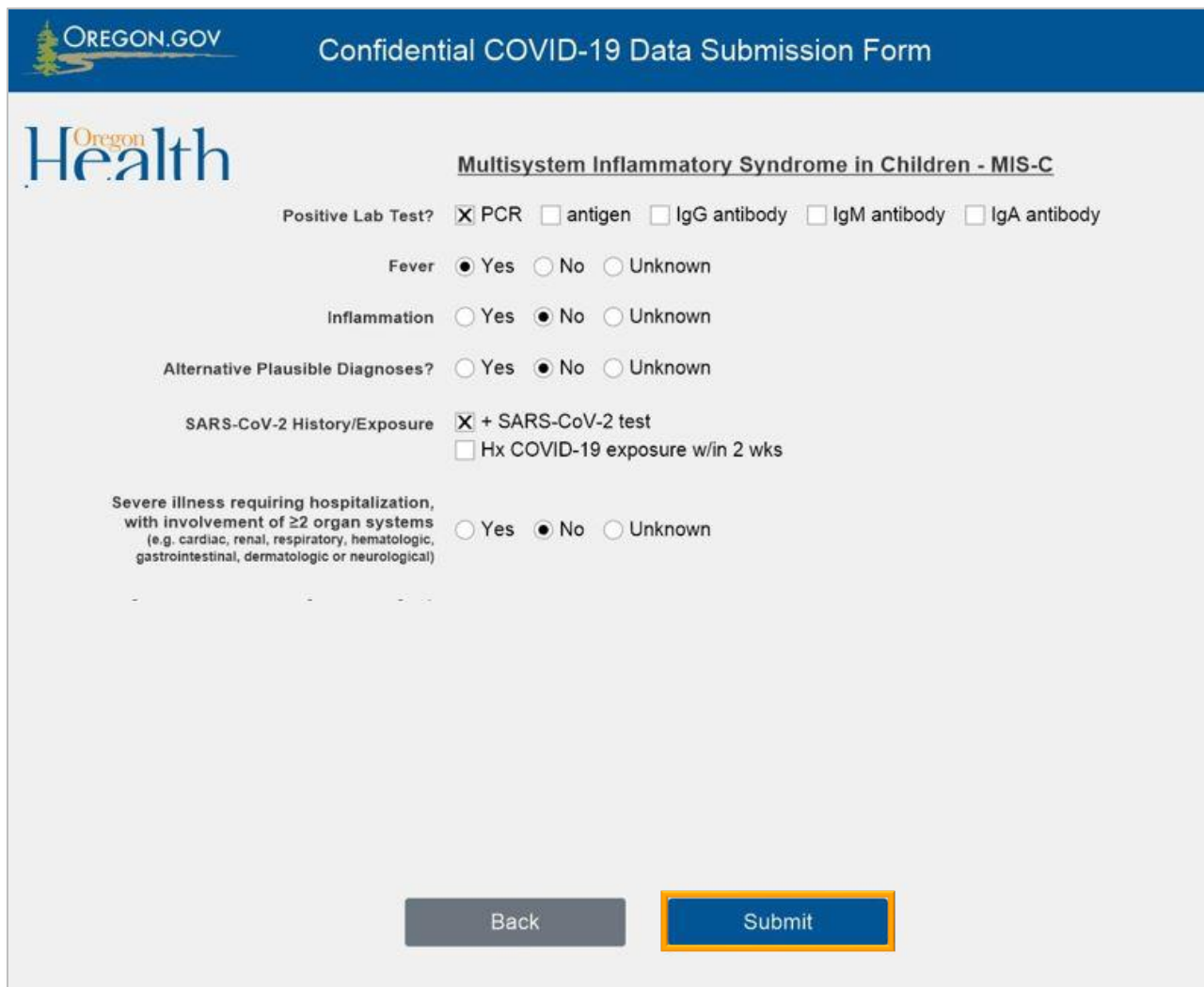
Device Identifier

Back

Submit

**Multisystem Inflammatory Syndrome in Children (MIS-C)**

1. Select the **Positive Lab Test**
2. Select whether the patient had a **Fever**
3. Select whether the patient had an **Inflammation**
4. Select whether the patient had an **Alternative Plausible Diagnoses**
5. Select the **SARS-CoV-2 History/Exposure**
6. Select whether the patient had a **Severe illness requiring hospitalization with involvement of  $\geq 2$  organ systems**
7. Review all information from all sections and confirm the information is correct and accurate  
**NOTE:** Once you click on **Submit**, you will not be able to edit your submission. Please review your submission first.
8. Click on **Submit**
9. Skip ahead to [Printing the Report for Your Records](#)



**OREGON.GOV** Confidential COVID-19 Data Submission Form

**Oregon Health**

**Multisystem Inflammatory Syndrome in Children - MIS-C**

Positive Lab Test? ☒ PCR ☐ antigen ☐ IgG antibody ☐ IgM antibody ☐ IgA antibody

Fever ☒ Yes ☐ No ☐ Unknown

Inflammation ☐ Yes ☒ No ☐ Unknown

Alternative Plausible Diagnoses? ☐ Yes ☒ No ☐ Unknown

SARS-CoV-2 History/Exposure ☒ + SARS-CoV-2 test  
☐ Hx COVID-19 exposure w/in 2 wks

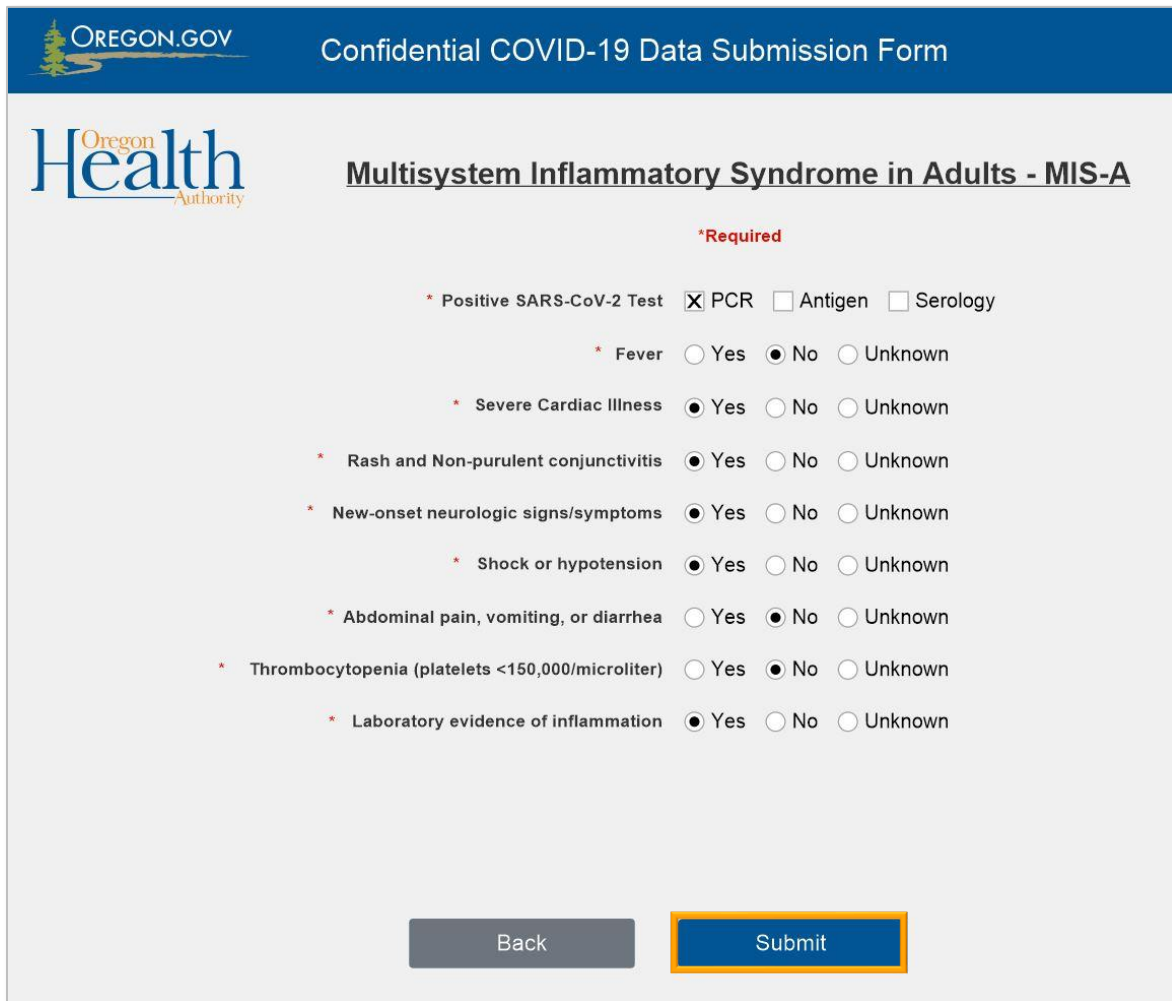
Severe illness requiring hospitalization, with involvement of  $\geq 2$  organ systems (e.g. cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic or neurological) ☐ Yes ☒ No ☐ Unknown

**Back** **Submit**




**Multisystem Inflammatory Syndrome in Adults (MIS-A)**

1. Select the **Positive SARS-Cov-2 Test**
2. Select whether the patient had a **Fever**
3. Select whether the patient had a **Severe Cardiac Illness**
4. Select whether the patient had a **Rash and Non-purulent conjunctivitis**
5. Select whether the patient had a **New-onset neurologic signs/symptoms**
6. Select whether the patient had **Shock or hypertension**
7. Select whether the patient had **Abdominal pain, vomiting, or diarrhea**
8. Select whether the patient had **Thrombocytopenia (platelets <150,000/microliter)**
9. Select whether the patient had **Laboratory evidence of inflammation**
10. Review all information from all sections and confirm the information is correct and accurate  
**NOTE:** Once you click on **Submit**, you will not be able to edit your submission. Please review your submission first.
11. Click on **Submit**



OREGON.GOV

Confidential COVID-19 Data Submission Form

 **Multisystem Inflammatory Syndrome in Adults - MIS-A**

**\*Required**

\* Positive SARS-CoV-2 Test ☒ PCR ☐ Antigen ☐ Serology

\* Fever ☐ Yes ☒ No ☐ Unknown

\* Severe Cardiac Illness ☒ Yes ☐ No ☐ Unknown

\* Rash and Non-purulent conjunctivitis ☒ Yes ☐ No ☐ Unknown

\* New-onset neurologic signs/symptoms ☒ Yes ☐ No ☐ Unknown

\* Shock or hypotension ☒ Yes ☐ No ☐ Unknown

\* Abdominal pain, vomiting, or diarrhea ☐ Yes ☒ No ☐ Unknown

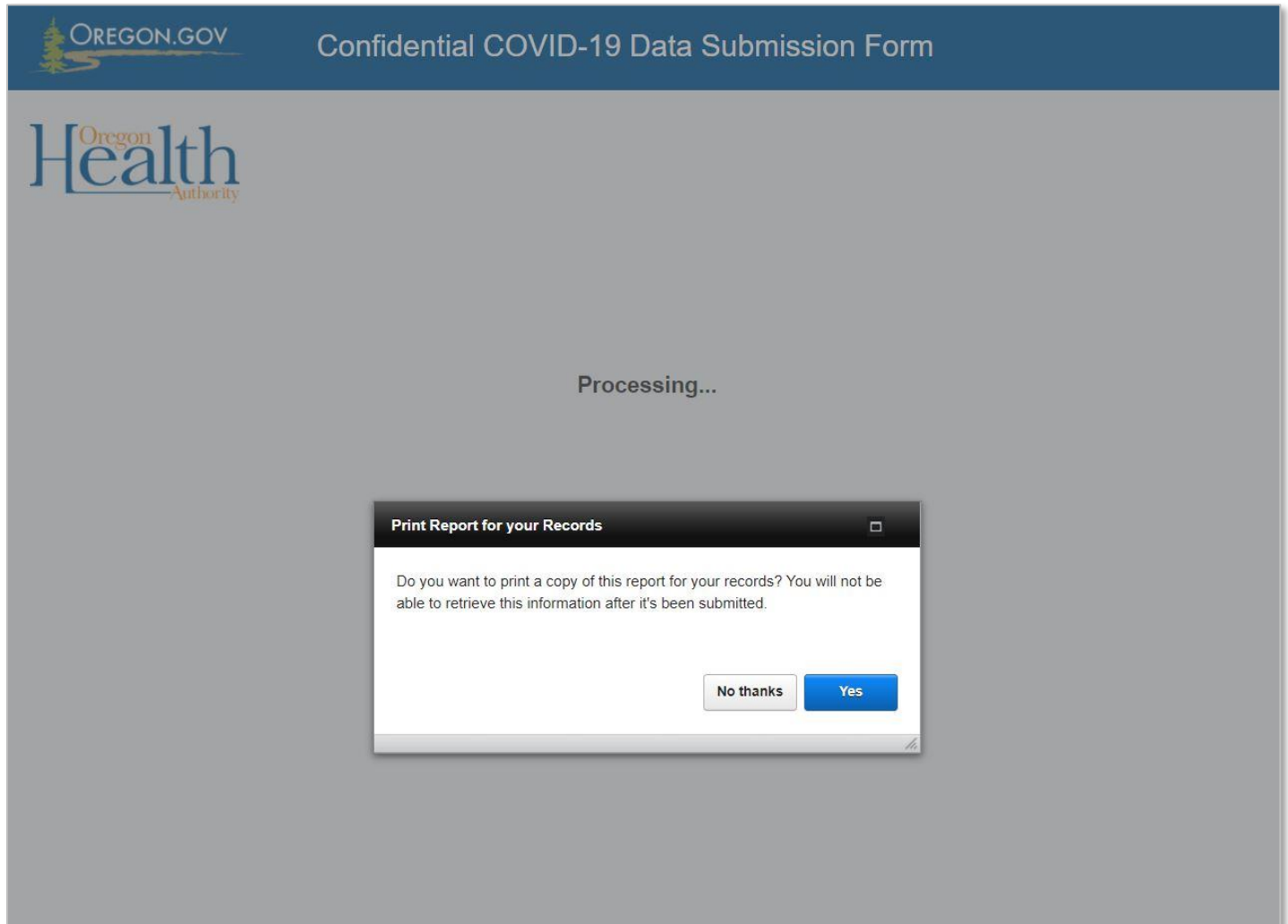
\* Thrombocytopenia (platelets <150,000/microliter) ☐ Yes ☒ No ☐ Unknown

\* Laboratory evidence of inflammation ☒ Yes ☐ No ☐ Unknown

Back Submit

### Printing the Report for Your Records


1. To print the report for your records, click **Yes** in the popup box
2. Once you have printed the report, click **Done**
3. To exit or submit another report, click **No thanks**




The screenshot shows a web interface for the 'Confidential COVID-19 Data Submission Form'. At the top, there is a dark blue header with the 'OREGON.GOV' logo and the text 'Confidential COVID-19 Data Submission Form'. Below the header, the 'Oregon Health Authority' logo is visible on the left. The main content area is a light gray rectangle with the text 'Processing...' centered. A modal popup box titled 'Print Report for your Records' is displayed in the center. The popup contains the text: 'Do you want to print a copy of this report for your records? You will not be able to retrieve this information after it's been submitted.' At the bottom of the popup are two buttons: 'No thanks' and 'Yes'.

### Submitting Another File / Confirmation Code

1. Keep track of the **Confirmation code**  
**NOTE:** For assistance with your submission, you will need this confirmation code.
2. To submit another file, click on **Submit Another File**
3. To exit, close your browser
4. Thank you!

 **Confidential COVID-19 Data Submission Form**



Thank you for submitting your file.

Confirmation code: 56B1B1BED62C

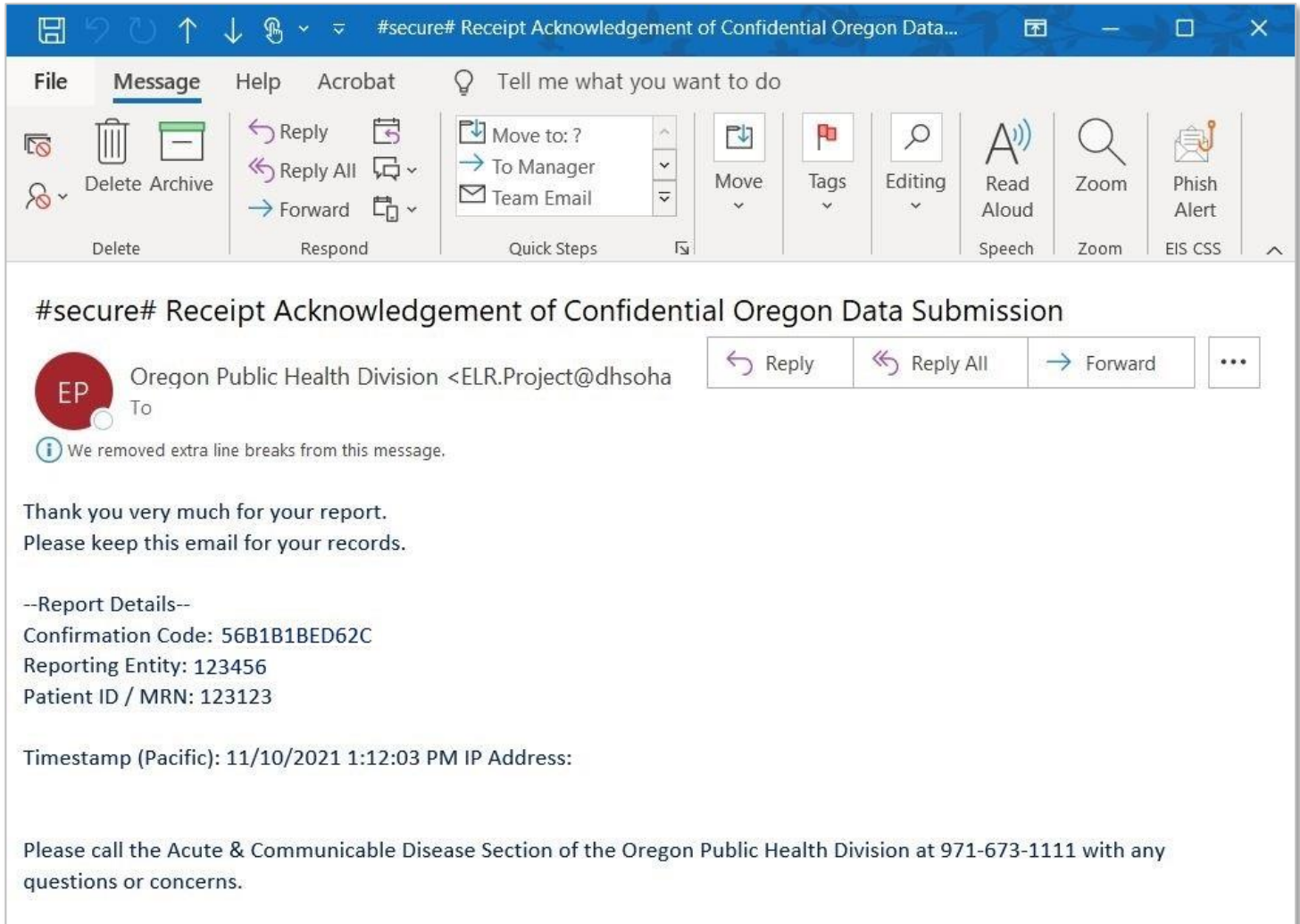
A confirmation email will be sent to [Example@email.com](mailto:Example@email.com)

[Submit Another File](#)

For questions or concerns, contact: [Opera.Support@dhsosha.state.or.us](mailto:Opera.Support@dhsosha.state.or.us)

## Email Notification

- Once you have submitted a report, you will receive a secure email with the subject: **#secure# Receipt Acknowledgement of Confidential Oregon Data Submission**
- This email is automatically sent from [ELR.Project@dhsosha.state.or.us](mailto:ELR.Project@dhsosha.state.or.us) after each submission.
- If you have trouble opening this secure email, please contact [Opera.Support@dhsosha.state.or.us](mailto:Opera.Support@dhsosha.state.or.us)



## Other Questions?

For any technical assistance, please contact [Opera.Support@dhsosha.state.or.us](mailto:Opera.Support@dhsosha.state.or.us).

Please include the confirmation code of the submission (you can find this code in the secure email that was sent to you after your OCRP submission).

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You can get this document in other languages, large print, braille, or a format you prefer. Contact the Coronavirus Response and Recovery Unit (CRRU) at 503-979-3377 or email [CRRU@dhsosha.state.or.us](mailto:CRRU@dhsosha.state.or.us). We accept all relay calls, or you can dial 711.

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