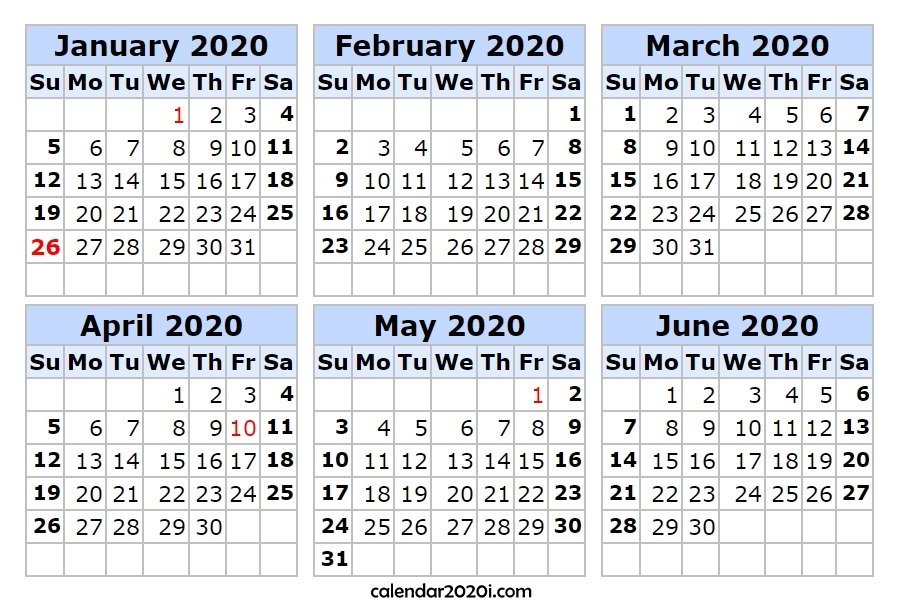
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| 1. **INTERVIEW INFORMATION** |
| Confirmed case name: Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sex: Male/ Female Date of birth: MM / DD / YYYY  Date of interview: MM / DD / YYYY  Interviewer name Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Who is providing information for this form?  Confirmed case  Other, specify person (Last, First): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to confirmed case: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 1. **GENERAL INFORMATION** |
| Healthcare personnel role (check all that apply):   |  |  |  |  | | --- | --- | --- | --- | | Environmental services worker | Nurse practitioner | Phlebotomist | Radiology technician | | Facilities/maintenance worker | Nursing assistant | Physical therapist | Registered nurse | | Food services worker | Nutritionist | Physician assistant | Respiratory therapist | | Laboratory worker | Occupational therapist | Physician (intern/resident) | Speech therapist | | Licensed practical nurse | Ward clerk | Physician (fellow) | Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Medical technician | Pharmacy worker | Physician (attending) | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   Date of first symptom onset (e.g., fever, cough, shortness of breath, sore throat): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Describe the course of symptoms since onset:  Did you seek care at any healthcare facility while symptomatic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have symptoms resolved, and if so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of last shift at work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dates and shifts worked after symptom onset:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Facility Name | Date | Shift Time | Location (i.e., unit) | Role | Symptoms Present | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |

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| 1. **WORK HISTORY FROM DAY OF SYMPTOM ONSET: GENERAL PATIENT CARE ACTIVITIES** | | | | |
| **General patient care activities and procedures during this time period.** In your role, what patient care activities do you typically perform? Complete this table if it is infeasible to describe all patient interactions individually. (check all that apply):  **Patient care activities and procedures (excluding AGP):**   |  |  |  |  | | --- | --- | --- | --- | | Taking vital signs  Taking medical history  Performing physical exam  Providing medication | Placing urinary catheter  Bathing  Feeding  Lifting, positioning | Emptying bedpan  Changing linen  Providing injection  Placing intravascular device | Hemodialysis  Drawing blood  Collecting respiratory specimens  Performing X-ray | | Manipulation of oxygen face mask or tubing  Manipulation ventilator  Other: | Chest tube (insert or remove)  Insertion of nasogastric tubes  Insertion of peripheral line | Insertion of central line  Tracheostomy care  ECMO | ABG  Participating in surgery  Hi flow oxygen delivery |   **Aerosol-generating procedures (AGP):**   |  |  |  |  | | --- | --- | --- | --- | | Airway suctioning  Non-invasive ventilation (e.g., BiPAP, CPAP)  Manual (bag) ventilation | Nebulizer treatments  Intubation  Code / CPR | High-frequency oscillatory ventilation (HFOV)  Chest physiotherapy  Mini BAL | Breaking ventilation circuit (intentionally or unintendedly)  Sputum induction  Bronchoscopy |   **Describe any other patient care activities:** | | | | |
| **Based on above patient care activities, define the categories of contact.\***  **(Check the highest tier)** | **What was the typical amount of time you spend providing care for each patient on a shift? (Specify a range)** | **What PPE did you wear during this time period?**  **(Check all that apply)** | **What symptoms did you have while you were working during this period?**  **(Check all that apply)** | **Were patient visitors present?** |
| Tier 4: Prolonged\*\* direct contact (e.g., bathing, toileting, feeding, changing linens, lifting/positioning, placing urinary catheter)  Tier 3: Brief direct contact (e.g., taking vital signs, performing physical exam, providing oral medication)  Tier 2: Prolonged indirect contact (e.g., cleaning surfaces and equipment in the patient’s room, removing waste and soiled linens)  Tier 1: Brief indirect contact (e.g., silencing alarms)  \* Direct and indirect contact based on the CDC [Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings](https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html).  \*\* It is not possible to define the duration of time that constitutes a prolonged exposure. It would be reasonable to consider anything longer than a brief (e.g., less than 1 to 2 minutes) exposure as prolonged. | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  minutes  hours | Gloves  Gown  N95 respirator  PAPR  Facemask  Goggles or face shield  **Did you wear PPE above what was indicated for Standard Precautions (e.g., Transmission-Based Precautions, HCP source control)?**  No  Yes  If yes, describe: | Coughing  Runny nose  Sneezing  Diarrhea  Other: | No  Yes  If yes, names, contact information, and dates of last exposure to HCP: |
| 1. **WORK HISTORY FROM DAY OF SYMPTOM ONSET: INDIVIDUAL PATIENTS** | | | | |
| **Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Dates of Contact:** | | **Admission Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Patient Care Activities:** | | |
| **Based on above patient care activities, define the categories of contact.\***  **(Check the highest tier)** | **What was the typical amount of time you spend providing care for each patient on a shift? (Specify a range)** | **What PPE were you wearing?**  **(Check all that apply)** | **What symptoms did you have while you were caring for this patient?**  **(Check all that apply)** | **Were patient visitors present?** |
| Tier 4: Prolonged\*\* direct contact (e.g., bathing, toileting, feeding, changing linens, lifting/positioning, placing urinary catheter)  Tier 3: Brief direct contact (e.g., taking vital signs, performing physical exam, providing oral medication)  Tier 2: Prolonged indirect contact (e.g., cleaning surfaces and equipment in the patient’s room, removing waste and soiled linens)  Tier 1: Brief indirect contact (e.g., silencing alarms)  \* Direct and indirect contact based on the CDC [Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings](https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html).  \*\* It is not possible to define the duration of time that constitutes a prolonged exposure. It would be reasonable to consider anything longer than a brief (e.g., less than 1 to 2 minutes) exposure as prolonged. | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  minutes  hours | Gloves  Gown  N95 respirator  PAPR  Facemask  Goggles or face shield  **Did you wear PPE above what was indicated for Standard Precautions (e.g., Transmission-Based Precautions, HCP source control)?**  No  Yes  If yes, describe: | Coughing  Runny nose  Sneezing  Diarrhea  Other: | No  Yes  If yes, names, contact information, and dates of last exposure to HCP: |

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| 1. **CONTACTS WITH OTHER HEALTHCARE PERSONNEL** |
| Please complete the table below for all healthcare personnel with whom you had close contact. For the purposes of this table,  **Close contact is defined as follows:**  A: Being within approximately 6 feet (2 meters), of HCP with COVID-19 for a prolonged period of time (such as eating lunch together in the break room), or  B: Having unprotected direct contact with infectious secretions or excretions of HCP (e.g., being coughed on, touching used tissues with a bare hand)  NOTE: Print additional pages for additional HCP close contacts.   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Name of Contact** | **Location**  **of Contact**  **(e.g., break room)** | **Description and**  **Duration of Contact**  **(e.g., hug, touched tissues)** | **Close Contact Type**  **(A or B)** | **Date of**  **last exposure to the HCP case**  **(MM/DD/YYYY)** | **Phone Number**  **(if known)** | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |
| 1. **NOTES** |
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