**Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_ □ Check box if documented case**

|  |  |
| --- | --- |
| A. Employee Background | 1. Study Number: \_\_\_ \_\_\_ \_\_\_  |
| 2. Age: |   |  |  | 3. Sex: Male Female |
| 4. City of Residence: | 6. List occupation: RN/LPN CNA PT/OT RNA  Housekeeping Dietary Physician Pharmacist Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 5. State of Residence: |
| **B. Job Description** | 7. As part of your job, do you have physical contact with patients? Yes No |
| 8. Areas usually worked: Patient rooms Nurses’ station Cafeteria Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_9. Shifts usually worked: Day Evening Night Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_10. Patient units usually worked: 3W 2W 3E 2E Do not work in patient units All patient units11. Which days do you usually work *(circle ALL that apply)*: |
|

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| --- | --- | --- | --- | --- | --- | --- |
| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |

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| 12. What kind of patient contact do you have? *(check ALL that apply)* Give oral medications Feeding resident Respiratory therapy Tracheostomy care  Change dressings/wound care Gastrostomy care Handle urinary catheter Bathe resident  Assist with patient transfer Clean room Handle soiled linens/bedding Handle soiled diapers/bedpans Deliver meal trays Take vital signs  |

|  |  |
| --- | --- |
| **C. Work Practice** | 13. Do you use soap and water to clean your hands? Yes No14. Do you use alcohol-based gel to clean your hands? Yes No |
| 15. Please answer the following questions *(circle answer)* Never Alwaysa. Do you wash your hands BEFORE physical contact with patients? 1 2 3 4 5 N/Ab. Do you wash your hands AFTER physical contact with patients? 1 2 3 4 5 N/Ac. Do you wash your hands BETWEEN contact with patients? 1 2 3 4 5 N/Ad. Do you use the sink in the patient’s bathroom? 1 2 3 4 5 N/Ae. Do you use the sink at the nurse’s station? 1 2 3 4 5 N/Af. Do you use gloves when changing bandages/dressing wounds? 1 2 3 4 5 N/A If yes, do you change gloves between patients/patient rooms? 1 2 3 4 5 N/Ag. Do you use gloves when cleaning soiled patients or linens? 1 2 3 4 5 N/A If yes, do you change gloves between patients/patient rooms? 1 2 3 4 5 N/Ah. Do you use gloves when bathing patients? 1 2 3 4 5 N/A |   |
| **D. Your Health** | 16. Do you have paid “Sick Leave”? Yes No17. Did you receive prophylaxis for Group A Streptococcus infection? Yes No If yes, when? \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ |
| 18 a. Since May 2, 2015, did you have a sore throat? Yes No *(If no, skip to #19)* b. When? \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_  c. Were you diagnosed with strep throat? Yes No d. Did you miss work for this illness? Yes No How many days did you miss? \_\_\_\_\_\_\_\_\_\_\_\_ e. How many days were you ill? \_\_\_\_\_\_\_\_\_\_\_\_\_ f. Did you receive antibiotics for this condition? Yes No If yes, antibiotic name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 19 a. Since May 2, 2015, did you have a rash, open wound, or skin infection? Yes No *(If no, skip to #20)* b. When? \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_  c. Did you miss work for this illness? Yes No How many days did you miss? \_\_\_\_\_\_\_\_\_\_\_\_ d. How many days were you ill? \_\_\_\_\_\_\_\_\_\_\_\_\_ e. Did you receive antibiotics for this condition? Yes No If yes, antibiotic name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ f. What was your diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 20 a. Since May 2, 2015, did you have fever, cough, and/or other respiratory infection? Yes No *(If no, skip to #21)* b. When? \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_  c. Did you miss work for this illness? Yes No How many days did you miss? \_\_\_\_\_\_\_\_\_\_\_\_ d. How many days were you ill? \_\_\_\_\_\_\_\_\_\_\_\_\_ e. Did you receive antibiotics for this condition? Yes No If yes, antibiotic name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ f. What was your diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 21 a. How many people are in your household? \_\_\_\_\_\_\_\_\_\_ *(If none, END)* b. How many children under 18 years of age are in your household? \_\_\_\_\_\_\_\_\_ c. During the past 3 months, did anyone in your household have a sore throat? Yes No d. When? \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_  e. Was he/she diagnosed with strep throat? Yes No f. Who? \_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ g. Were they treated? Yes No If so, with what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ h. During the past 3 months, did anyone in your household have impetigo or cellulitis (skin infections)? Yes No i. When? \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ |
| 22 a. Do you work in another patient-care facility? Yes No *(If no, skip to End)* b. Name of facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ c. Have you been in contact with a patient infected with group A Strep in that facility? Yes No *(If no, skip to End)* d. When? \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ e. What was that patient’s diagnosis? Strep throat Impetigo Cellulitis Bacteremia Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**END – *Thank you!***