Form Approved

OMB No. 0920-1011

Exp. Date 03/31/2017

**Healthcare Personnel Risk Assessment Questionnaire and Serosurvey for Zika Virus Exposure—Utah, 2016**

Public reporting burden of this collection of information is estimated to average 12 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

**Zika Virus Exposure Assessment for**

**Healthcare Personnel**

**Date of interview:**

**Name of interviewer:**

**Subject name:**

**Job Title:**

**Is contact information correct?**

**If no, please provide**

**Address:**

**Phone:**

**Where was interview administered (circle one)?**

 **Wellness clinic**

 **Phone**

**Home**

**Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has sample been collected?**

 **Yes**

**No**

**Not indicated at this time**

**Case or Control (circle one)**

**Section 1: Demographics, Role----------------------------------------------------------------------------**

1. **Gender**  [ ] Male [ ] Female
2. **Age**  \_\_\_\_\_\_\_\_\_\_\_ years
3. **Please indicate your job title at this facility**

[ ]  Laboratory staff [ ]  Environmental services [ ]  Nurse [ ]  Radiology tech

[ ]  Physician/Advanced Care Provider [ ]  Respiratory therapy [ ] Certified nursing assistant/Health care assistant

[ ]  Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **How long have you been working in your current role (at any facility)?** \_\_\_\_\_\_\_\_\_\_\_\_\_ months/years

**Section 2: Risks and symptoms----------------------------------------------------------------------------**

**Country of origin:**

**Have you lived outside of the US?**  [ ]  Yes [ ]  No

**If yes, what countries have you lived in and when did you live there?**

|  |  |  |
| --- | --- | --- |
| **Country** | **Start date** | **End date** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Travel history (past year)**

|  |  |  |
| --- | --- | --- |
| Region/country | Start date (XX/XX/XXXX) | End date (XX/XX/XXXX) |
| Mexico |  |  |
| Cape Verde |  |  |
| Caribbean (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Puerto Rico |  |  |
| Central America (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Pacific Islands (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| South American (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Africa (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Asia (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**Vaccination history**

Previous vaccinations: [ ]  Yellow Fever Last dose:

 [ ]  Tick-borne Encephalitis Last dose:

 [ ]  Japanese Encephalitis Last dose:

**Pregnancy**

|  |  |  |
| --- | --- | --- |
| **Are you or your partner currently pregnant?**  | **[ ]  Yes [ ]  No [ ]  Unknown** | **If yes, test (group A)** |
| **Are you or your partner trying to become pregnant now?**  | **[ ]  Yes [ ]  No [ ]  Unknown** | **If yes, test (group A)** |
| **Are you or your partner planning to become pregnant in the next 6 months?** | **[ ]  Yes [ ]  No [ ]  Unknown** | **If yes, test** |

**Symptoms (developed since patient interaction)**

|  |  |
| --- | --- |
| Fever [ ]  Yes [ ]  NoIf yes, dates \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_ [ ] Subjective [ ] Measured  (Max measured temperature: \_\_\_\_\_\_\_F/C) | Rash [ ]  Yes [ ]  NoIf yes, dates \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_Type: [ ]  Maculopapular [ ]  Petechial  [ ]  Purpuric [ ]  OtherPruritic: [ ]  Yes [ ]  No Distribution:­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Arthralgia [ ]  Yes [ ]  NoIf yes, dates \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_ | Conjunctivitis [ ]  Yes [ ]  No If yes, dates \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_ |

Do they have 2 or more symptoms occurring within one week?

|  |  |
| --- | --- |
| If no | [ ]  Asymptomatic  |
| **If yes** | **[ ]  Symptomatic** |

If symptomatic, are you currently symptomatic or have been symptomatic in the past 14 days?

|  |  |
| --- | --- |
| [ ]  No |  |
| **[ ]  Yes**  | **Call Dr. Rubin for further instructions**  |

If symptomatic, were symptoms more than 14 days ago?

|  |  |
| --- | --- |
| [ ]  No |  |
| **[ ]  Yes**  |  **If yes, test (group B)** |

**Section 3: Patient Interaction------------------------------------------------------------------------------**

**Days with any patient interaction?**

6/19 6/20 6/22 6/23 6/24 6/25

|  |
| --- |
| Site interaction occurred [ ] ER [ ] ECU [ ] Ward [ ] ICU [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ] Patient care[ ] Device reprocessing[ ] Environmental cleaning[ ] Food service needs[ ] Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Did you enter patient’s room or care area?Yes No | If yes, then low  |
| **Did you touch patient?****Yes No** | **If yes, then** **medium and test (group B)** |
| **Did you (circle all that apply):****Have any contact with blood or body fluids?****Clean up vomit?****Clean up stool?****Draw blood?****Collect urine sample or empty Foley bag?****Collect stool sample?****Wipe away sweat?****Wipe away tears?****Suction or manipulate airway?****Place Foley?****Place or manipulate rectal tube?****Reposition the patient?****Bathe the patient?****Change linens?****Perform physical exam?****Perform radiology exam or Echo?****Device reprocessing?****Perform procedure (please specify)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **If any circled, then** **high and test (group B)** |
| Cumulative time in room in hours< 1 hour1 to 2 hours 59 minutes 3 to 5 hours 59 minutes 6 or more hours |

**Did you have any contact with blood or body fluids?** **[ ]  Yes [ ]  No**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Body fluid | What were you doing? | Was this protected (PPE)? | What PPE did you typically wear? | Did you have visible soilage of PPE? | Areas of contact (pick all that apply)? |
| Blood# times | [ ]  Phlebotomy[ ]  Procedure[ ]  Equipment[ ]  Soiled linen[ ]  Contaminated surface[ ]  Biohazard waste[ ]  Cleaning[ ]  Other (please specify)\_\_\_\_\_\_\_\_ | [ ]  Yes[ ]  No | [ ]  Face shield[ ]  Goggles [ ]  Facemask [ ]  Respirator/N95[ ]  Gloves [ ]  Gown [ ]  Other (please specify):\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No | [ ] Protected Not protected[ ]  Intact skin[ ]  Broken skin[ ]  Mucous membranes (please specify)\_\_\_\_\_\_\_\_[ ]  Percutaneous exposure[ ]  Other (please specify\_\_\_\_\_\_\_\_\_ |
| Respiratory# times | [ ]  Phlebotomy[ ]  Procedure[ ]  Equipment[ ]  Soiled linen[ ]  Contaminated surface[ ]  Biohazard waste[ ]  Cleaning[ ]  Other (please specify)\_\_\_\_\_\_\_\_ | [ ]  Yes[ ]  No | [ ]  Face shield[ ]  Goggles [ ]  Facemask [ ]  Respirator/N95[ ]  Gloves [ ]  Gown [ ]  Other (please specify):\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No | [ ] Protected Not protected[ ]  Intact skin[ ]  Broken skin[ ]  Mucous membranes (please specify)\_\_\_\_\_\_\_\_[ ]  Percutaneous exposure[ ]  Other (please specify\_\_\_\_\_\_\_\_\_ |
| Stool# times | [ ]  Phlebotomy[ ]  Procedure[ ]  Equipment[ ]  Soiled linen[ ]  Contaminated surface[ ]  Biohazard waste[ ]  Cleaning[ ]  Other (please specify)\_\_\_\_\_\_\_\_ | [ ]  Yes[ ]  No | [ ]  Face shield[ ]  Goggles [ ]  Facemask [ ]  Respirator/N95[ ]  Gloves [ ]  Gown [ ]  Other (please specify):\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No | [ ] Protected Not protected[ ]  Intact skin[ ]  Broken skin[ ]  Mucous membranes (please specify)\_\_\_\_\_\_\_\_[ ]  Percutaneous exposure[ ]  Other (please specify\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Body fluid | What were you doing? | Was this protected (PPE)? | What PPE did you typically wear? | Did you have visible soilage of PPE? | Areas of contact (pick all that apply)? |
| Urine# times | [ ]  Phlebotomy[ ]  Procedure[ ]  Equipment[ ]  Soiled linen[ ]  Contaminated surface[ ]  Biohazard waste[ ]  Cleaning[ ]  Other (please specify)\_\_\_\_\_\_\_\_ | [ ]  Yes[ ]  No | [ ]  Face shield[ ]  Goggles [ ]  Facemask [ ]  Respirator/N95[ ]  Gloves [ ]  Gown [ ]  Other (please specify):\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No | [ ] Protected Not protected[ ]  Intact skin[ ]  Broken skin[ ]  Mucous membranes (please specify)\_\_\_\_\_\_\_\_[ ]  Percutaneous exposure[ ]  Other (please specify\_\_\_\_\_\_\_\_\_ |
| Vomitus# times | [ ]  Phlebotomy[ ]  Procedure[ ]  Equipment[ ]  Soiled linen[ ]  Contaminated surface[ ]  Biohazard waste[ ]  Cleaning[ ]  Other (please specify)\_\_\_\_\_\_\_\_ | [ ]  Yes[ ]  No | [ ]  Face shield[ ]  Goggles [ ]  Facemask [ ]  Respirator/N95[ ]  Gloves [ ]  Gown [ ]  Other (please specify):\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No | [ ] Protected Not protected[ ]  Intact skin[ ]  Broken skin[ ]  Mucous membranes (please specify)\_\_\_\_\_\_\_\_[ ]  Percutaneous exposure[ ]  Other (please specify\_\_\_\_\_\_\_\_\_ |
| Tears# times | [ ]  Phlebotomy[ ]  Procedure[ ]  Equipment[ ]  Soiled linen[ ]  Contaminated surface[ ]  Biohazard waste[ ]  Cleaning[ ]  Other (please specify)\_\_\_\_\_\_\_\_ | [ ]  Yes[ ]  No | [ ]  Face shield[ ]  Goggles [ ]  Facemask [ ]  Respirator/N95[ ]  Gloves [ ]  Gown [ ]  Other (please specify):\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No | [ ] Protected Not protected[ ]  Intact skin[ ]  Broken skin[ ]  Mucous membranes (please specify)\_\_\_\_\_\_\_\_[ ]  Percutaneous exposure[ ]  Other (please specify\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Body fluid | What were you doing? | Was this protected (PPE)? | What PPE did you typically wear? | Did you have visible soilage of PPE? | Areas of contact (pick all that apply)? |
| Sweat# times | [ ]  Phlebotomy[ ]  Procedure[ ]  Equipment[ ]  Soiled linen[ ]  Contaminated surface[ ]  Biohazard waste[ ]  Cleaning[ ]  Other (please specify)\_\_\_\_\_\_\_\_ | [ ]  Yes[ ]  No | [ ]  Face shield[ ]  Goggles [ ]  Facemask [ ]  Respirator/N95[ ]  Gloves [ ]  Gown [ ]  Other (please specify):\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No | [ ] Protected Not protected[ ]  Intact skin[ ]  Broken skin[ ]  Mucous membranes (please specify)\_\_\_\_\_\_\_\_[ ]  Percutaneous exposure[ ]  Other (please specify\_\_\_\_\_\_\_\_\_ |
| Other(Please specify) # times | [ ]  Phlebotomy[ ]  Procedure[ ]  Equipment[ ]  Soiled linen[ ]  Contaminated surface[ ]  Biohazard waste[ ]  Cleaning[ ]  Other (please specify)\_\_\_\_\_\_\_\_ | [ ]  Yes[ ]  No | [ ]  Face shield[ ]  Goggles [ ]  Facemask [ ]  Respirator/N95[ ]  Gloves [ ]  Gown [ ]  Other (please specify):\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No | [ ] Protected Not protected[ ]  Intact skin[ ]  Broken skin[ ]  Mucous membranes (please specify)\_\_\_\_\_\_\_\_[ ]  Percutaneous exposure[ ]  Other (please specify\_\_\_\_\_\_\_\_\_ |
| Other(Please specify) # times | [ ]  Phlebotomy[ ]  Procedure[ ]  Equipment[ ]  Soiled linen[ ]  Contaminated surface[ ]  Biohazard waste[ ]  Cleaning[ ]  Other (please specify)\_\_\_\_\_\_\_\_ | [ ]  Yes[ ]  No | [ ]  Face shield[ ]  Goggles [ ]  Facemask [ ]  Respirator/N95[ ]  Gloves [ ]  Gown [ ]  Other (please specify):\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No | [ ] Protected Not protected[ ]  Intact skin[ ]  Broken skin[ ]  Mucous membranes (please specify)\_\_\_\_\_\_\_\_[ ]  Percutaneous exposure[ ]  Other (please specify\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **Were you involved with any procedures (either performing or in room)?** |
| Intubation | [ ]  Performed or assisted with procedure[ ] Present in room  | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Central line placement | [ ]  Performed or assisted with procedure[ ] Present in room | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Bronchoscopy | [ ]  Performed or assisted with procedure[ ] Present in room | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| CPR | [ ]  Performed or assisted with procedure[ ] Present in room | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sputum induction | [ ]  Performed or assisted with procedure[ ] Present in room | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Extubation | [ ]  Performed or assisted with procedure[ ] Present in room | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Airway suctioning | [ ]  Performed or assisted with procedure[ ] Present in room | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Nasogastric tube placement | [ ]  Performed or assisted with procedure[ ] Present in room | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Nebulizer treatment | [ ]  Performed or assisted with procedure[ ] Present in room | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dialysis | [ ]  Performed or assisted with procedure[ ] Present in room | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Rectal tube placement or manipulation | [ ]  Performed or assisted with procedure[ ] Present in room | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Arterial line placement | [ ]  Performed or assisted with procedure[ ] Present in room | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Peripheral IV placement | [ ]  Performed or assisted with procedure[ ] Present in room | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Noninvasive ventilation | [ ]  Performed or assisted with procedure[ ] Present in room | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Lumbar puncture | [ ]  Performed or assisted with procedure[ ] Present in room | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Performed or assisted with procedure[ ] Present in room | [ ]  Face shield [ ]  Goggles [ ]  Facemask [ ]  Respirator/N95 [ ]  Gloves [ ]  Gown [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Did you come into contact with body following death? Yes No

Did you have any other contact with the patient not previously mentioned?

**Section 4: PPE training---------------------------------------------------------------------------------------**

Have you received training on proper selection of PPE for standard precautions? [ ]  Yes [ ]  No

Have you received training on how to don:

 Gloves? [ ]  Yes [ ]  No

 Gown? [ ]  Yes [ ]  No

 Eye protection? [ ]  Yes [ ]  No

Have you received training on how to doff (so as not to contaminate):

 Gloves? [ ]  Yes [ ]  No

 Gown? [ ]  Yes [ ]  No

 Eye protection? [ ]  Yes [ ]  No

How often does this training occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you last receive training? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you required to demonstrate competency? [ ]  Yes [ ]  No