

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

ID _____

**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)

ID _____

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) _____

4. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, test (group A)
Are you or your partner trying to	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, test (group A)

ID _____

become pregnant now?		
Are you or your partner planning to become pregnant in the next 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, test

Symptoms (developed since patient interaction)

Fever <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, dates _____ to _____ <input type="checkbox"/> Subjective <input type="checkbox"/> Measured (Max measured temperature: _____ F/C)	Rash <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, dates _____ to _____ Type: <input type="checkbox"/> Maculopapular <input type="checkbox"/> Petechial <input type="checkbox"/> Purpuric <input type="checkbox"/> Other Pruritic: <input type="checkbox"/> Yes <input type="checkbox"/> No Distribution: _____
Arthralgia <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, dates _____ to _____	Conjunctivitis <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, dates _____ to _____

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

If no	<input type="checkbox"/> Asymptomatic
If yes	<input type="checkbox"/> Symptomatic

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

<input type="checkbox"/> No	
<input type="checkbox"/> Yes	Call Dr. Rubin for further instructions

If symptomatic, were symptoms more than 14 days ago?

<input type="checkbox"/> No	
<input type="checkbox"/> 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 <input type="checkbox"/> ER <input type="checkbox"/> ECU <input type="checkbox"/> Ward <input type="checkbox"/> ICU <input type="checkbox"/> Other _____	
<input type="checkbox"/> Patient care <input type="checkbox"/> Device reprocessing <input type="checkbox"/> Environmental cleaning <input type="checkbox"/> Food service needs <input type="checkbox"/> 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 hour 1 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	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> Other (please specify)_____
Respiratory # times	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> Other (please specify)_____
Stool # times	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> 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	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> Other (please specify)_____
Vomitus # times	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> Other (please specify)_____
Tears # times	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> 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	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> Other (please specify)_____
Other (Please specify) _____ # times	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure <input type="checkbox"/> Other (please specify)_____
Other (Please specify) _____ # times	<input type="checkbox"/> Phlebotomy <input type="checkbox"/> Procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Soiled linen <input type="checkbox"/> Contaminated surface <input type="checkbox"/> Biohazard waste <input type="checkbox"/> Cleaning <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify):_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protected Not protected <input type="checkbox"/> Intact skin <input type="checkbox"/> Broken skin <input type="checkbox"/> Mucous membranes (please specify)_____ <input type="checkbox"/> Percutaneous exposure

					<input type="checkbox"/> Other (please specify _____)
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Were you involved with any procedures (either performing or in room)?					
Intubation	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____			
Central line placement	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____			
Bronchoscopy	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____			
CPR	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____			
Sputum induction	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____			
Extubation	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____			
Airway suctioning	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____			
Nasogastric tube placement	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____			
Nebulizer treatment	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____			
Dialysis	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____			
Rectal tube placement or manipulation	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____			
Arterial line placement	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____			
Peripheral IV placement	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____			
Noninvasive ventilation	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____			

ID _____

Lumbar puncture	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> Other (please specify): _____
Other (please specify) _____	<input type="checkbox"/> Performed or assisted with procedure <input type="checkbox"/> Present in room	<input type="checkbox"/> Face shield <input type="checkbox"/> Goggles <input type="checkbox"/> Facemask <input type="checkbox"/> Respirator/N95 <input type="checkbox"/> Gloves <input type="checkbox"/> Gown <input type="checkbox"/> 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