Form Approved OMB No. 0920-1011 Exp. Date 01/31/2020

**Patient Screening Questionnaire** 

Public reporting burden of this collection of information is estimated to average 10 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)

Inswers are being provided on behalf of:  □ Self □ Chilld  lease answer the questions to the best of your ability. It is ok to say you don't know.  1. Our records show that you (your child) was diagnosed with RMSF in		Patient ID								
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1. Our records show that you (your child) was diagnosed with RMSF in		□ Child								
Yes / No / Don't know If no, please provide us with the approximate date in which you (your child) had RMSF:	Please	answer the questions to the best of your ability. It is ok to say you don't know.								
	1.									
correct? Yes / No / Don't know  3. After you left the hospital, where did you (your child) go?  Home Another hospital Nursing home Rehabilitation facility  Other Don't remember Name of facility: How long were you there?  4. On a scale of 1 to 5 how would you rate your (your child's) overall ability to function before your RMSF illness: (Unable to function in my daily life) 1 - 2 - 3 - 4 - 5 (perfectly able to function)  5. Do you feel like you (your child) has recovered fully from your RMSF illness? Yes / No / Don't know -If yes: how long did it take to get back to normal?If no: have your (your child's) symptoms improved over time? Yes / No / Don't know what symptoms are you (your child) still experiencing?If don't know, proceed to next question.										
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		·								
6. On a scale of 1 to 5 how would you rate your (your child's) overall ability to function since your (their) RMSF		If don't know, proceed to next question.								
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7.	dement	tia, Parl /	kinson's	Disease	_	n neurologic w	illness sir	nce your	(their) RI	MSF illne	ess (such a	s a stroke,
what was the illness?												
		when	was it di	agnose	d?							
8.	do at th Yes	nis time	?		you (your c	·	do befor	e your RI	MSF illne	ss that y	ou (they)	are unable to
	If yes:  please list which activities:											
		do you	ı think th	nis chan	ge is due to	your (their)	RMSF illn	ess?				

Patient ID \_\_\_\_ - \_\_\_