



**SARS-CoV-2 Louisiana Questionnaire V1 rev 5/04/2020**  
(Correctional Facility Transmission Investigation)  
**Day 3/4 Form**

**CDC ID:** \_\_\_\_\_

.....  
**Interviewee Information**

Booking or JDE Number: \_\_\_\_\_

Specimen ID

First: \_\_\_\_\_ Last: \_\_\_\_\_

Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YYYY)

CDC ID \_\_\_\_\_

**NOTE: This page is for paper records only. Do not scan for data entry into the electronic database.**



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**Administrative Information**

1. Interviewer Name: First: \_\_\_\_\_ Last: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
2. Housing location: Dorm: \_\_\_\_\_ Other: \_\_\_\_\_
3. At the dorm, the number of current: Staff present: \_\_\_\_\_ Cells: \_\_\_\_\_ Detainees: \_\_\_\_\_

**Symptoms**

4. Use no touch thermometer to record current temperature: \_\_\_\_\_ °F
5. Since we last visited you, have you experienced any of the following symptoms?

|   | Symptom Present Since Last Visit?   | Onset Date (mm/dd) | # of Days | Ongoing?                 |
|---|---|--------------------|-----------|--------------------------|
| Fever >100.4°F (38° C)                          | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk | ___/___            |           | <input type="checkbox"/> |
| Subjective fever (felt feverish, or hot/sweaty) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk | ___/___            |           | <input type="checkbox"/> |
| Chills  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk | ___/___            |           | <input type="checkbox"/> |
| Muscle aches (myalgia)                          | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk | ___/___            |           | <input type="checkbox"/> |
| Runny nose (rhinorrhea)                         | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk | ___/___            |           | <input type="checkbox"/> |
| Stuffy nose (nasal congestion)                  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk | ___/___            |           | <input type="checkbox"/> |
| Sore throat                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk | ___/___            |           | <input type="checkbox"/> |
| Cough (new onset or worsening of chronic cough) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk | ___/___            |           | <input type="checkbox"/> |
| Shortness of breath (dyspnea)                   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk | ___/___            |           | <input type="checkbox"/> |
| Abdominal pain                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk | ___/___            |           | <input type="checkbox"/> |
| Diarrhea (≥3 loose stools/24hr period)          | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk | ___/___            |           | <input type="checkbox"/> |
| Nausea  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk | ___/___            |           | <input type="checkbox"/> |

Public reporting burden of this collection of information is estimated to average 60 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).



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|  |   |         |                          |
|--|---|---------|--------------------------|
| Vomiting   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> | ___/___ | <input type="checkbox"/> |
|  | Unk   |         |                          |
| Headache   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> | ___/___ | <input type="checkbox"/> |
|  | Unk   |         |                          |
| Loss of taste <input type="checkbox"/> Complete <input type="checkbox"/> Partial | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> | ___/___ | <input type="checkbox"/> |
|  | Unk   |         |                          |
| Loss of smell <input type="checkbox"/> Complete <input type="checkbox"/> Partial | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> | ___/___ | <input type="checkbox"/> |
|  | Unk   |         |                          |
| Other, specify:  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> | ___/___ | <input type="checkbox"/> |
|  | Unk   |         |                          |

**Potential Exposure**

6. Since we last visited you, have you been around any people who appear to be sick with COVID-19 symptoms, such as a fever, cough, or shortness of breath?

Yes  No  Unknown (If yes, how many? \_\_\_\_\_)