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**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.**

## **Administrative Information**

1. Interviewer Name: First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / /
2. Housing [*detainee*] location: Division: \_\_\_\_\_\_ Tier:\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_
3. At the unit, the number of current: Staff present:\_\_\_\_\_\_ Cells:\_\_\_\_\_\_\_\_\_\_\_\_ Detainees:\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Interviewee: [ ]  Detainee

**Symptoms**

1. *Use no touch thermometer to record current temperature*: \_\_\_\_\_\_\_\_°F
2. In the last two weeks, have you experienced any of the following symptoms*?*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Symptom Present Last 2 Weeks? | Onset Date(mm/dd) | # of Days | Ongoing? | Last 2 Months? |
| Fever >100.4°F (38° C) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Subjective fever (felt feverish, or hot/sweaty) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Chills | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Muscle aches (myalgia) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Runny nose (rhinorrhea) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Stuffy nose (nasal congestion) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Sore throat | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Cough (new onset or worsening of chronic cough) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Shortness of breath (dyspnea) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Abdominal pain  | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Diarrhea (≥3 loose stools/24hr period) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Nausea | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Vomiting | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Headache | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Loss of taste [ ]  Complete [ ]  Partial  | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Loss of smell [ ]  Complete [ ]  Partial  | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Other, specify: | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |

**Facility Questions (these questions are about a typical day in the last two weeks)**

1. At this facility, how many different people are you in contact with (<6 ft) on an average day?\_\_\_\_\_\_\_\_\_\_
2. In the last two weeks, have you had handcuffs put on? *(\*Other than for this survey\*)*

[ ]  Yes [ ]  No [ ]  Unknown

If yes, how many times per day (1 time would be once per day having them put on and taken off)? \_\_\_\_\_

**Sanitation levels**

1. How many times per day do you wash or sanitize your hands (on average)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. When you wash your hands, do you use (check all that apply): [ ]  Soap & Water [ ]  Hand sanitizer [ ]  Water alone

 [ ]  Don’t wash hands [ ]  Unknown

1. When do you wash your hands (check all that apply)? [ ]  Before eating [ ]  After touching a shared phone

[ ]  After coughing or sneezing [ ]  After touching another person [ ]  After using the bathroom [ ]  After touching dirty laundry [ ]  After working [ ]  Never [ ]  Unknown

1. Have you worn a mask at the facility in the last 2 weeks? [ ]  Yes [ ]  No [ ]  Unknown
	1. If yes, what type of mask (check all that apply)? [ ]  Cloth [ ]  Surgical [ ]  Unknown

[ ]  Other, specify:\_\_\_\_\_\_\_\_\_

* 1. When around others (<6 ft), how often do you wear a mask?

[ ]  Always [ ]  Usually [ ]  Sometimes [ ]  Never [ ]  Unknown

* 1. When outside of your cell, how often do you wear a mask?

[ ]  Always [ ]  Usually [ ]  Sometimes [ ]  Never [ ]  Unknown

**Movement and Activity History**

1. While in this facility, have you done any of the following activities in the last two weeks?

|  |  |  |
| --- | --- | --- |
| Activity | Answer | Frequency |
| …shaken hands with a person?  | [ ]  Yes [ ]  No  | [ ]  Daily [ ]  A few times a week [ ]  Once a week  |
| …played cards or a game with a person?  | [ ]  Yes [ ]  No  | [ ]  Daily [ ]  A few times a week [ ]  Once a week  |
| …used a phone that is shared with others?  | [ ]  Yes [ ]  No  | [ ]  Daily [ ]  A few times a week [ ]  Once a week  |
| …used a computer that is shared with others?  | [ ]  Yes [ ]  No  | [ ]  Daily [ ]  A few times a week [ ]  Once a week  |
| …shared items with a person? (cards, checkers, remote control, basketball, pen, pencil, dominos, etc)  | [ ]  Yes [ ]  No  | [ ]  Daily [ ]  A few times a week [ ]  Once a week  |
| …exercised, worked out, or played sports with a person?  | [ ]  Yes [ ]  No  | [ ]  Daily [ ]  A few times a week [ ]  Once a week  |
| …slept in the same cell/room as a person? | [ ]  Yes [ ]  No  | [ ]  Daily [ ]  A few times a week [ ]  Once a week  |
| …shared a cigarette or vape pen with a person? | [ ]  Yes [ ]  No  | [ ]  Daily [ ]  A few times a week [ ]  Once a week  |
| …shared a plate, utensil, or drinking cup/glass with a person? | [ ]  Yes [ ]  No  | [ ]  Daily [ ]  A few times a week [ ]  Once a week  |
| …used a bathroom that is shared with others? | [ ]  Yes [ ]  No  | [ ]  Daily [ ]  A few times a week [ ]  Once a week  |
| …traveled in the same vehicle (car, bus), sitting within 6 feet of a person? | [ ]  Yes [ ]  No  | [ ]  Daily [ ]  A few times a week [ ]  Once a week  |
| …gone to court? (Excludes video court) | [ ]  Yes [ ]  No  | [ ]  Daily [ ]  A few times a week [ ]  Once a week  |
| … had a work assignment off your dorm? | [ ]  Yes [ ]  No  | [ ]  Daily [ ]  A few times a week [ ]  Once a week  |

**Potential Exposure**

1. In the last two weeks 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

## **SARS-CoV-2 testing**

1. Have you ever been offered a test for coronavirus? [ ]  Yes [ ]  No [ ]  Refused [ ]  Unknown
2. If yes, have you been tested for coronavirus? [ ]  Yes [ ]  No
	* 1. Date of most recent test:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MM/DD/YYYY)
		2. Did you experience any symptoms at the time you were tested? [ ]  Yes [ ]  No
		3. Result of most recent test: [ ]  Positive [ ]  Negative [ ]  Pending [ ]  Indeterminate [ ]  Don’t know [ ]  Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_