Form Approved. OMB No. 0920-1011 Exp. 08/05/2020

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

CDC ID: _________

<u>Interviewee Information</u>

Booking or JDE Number:______________________________

First:_____________________________ Last:_______________________________

Date of birth:____/____/______(MM/DD/YYYY)

CDC ID__________

Specimen ID

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

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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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)	☐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	___/___		☐

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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	___/___		☐

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? ________________________)

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