Form Approved
OMB No. 0920-1011
Exp. Date
1/31/2023

SARS-CoV-2 Correctional Facility Assessment

V7 rev 5/11/2020

(Correctional Facility Transmission Investigation)

Form Approved; OMB No. 0920-1011; Exp Date: 1/31/2023

SARS-CoV-2 Correctional Facility Assessment
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(Correctional Facility Transmission Investigation)

Unit Survey [Complete this survey for each unit of the facility enrolled.]

1. Facility Name:_____
2. Unit Name: _____
3. Location (building, floor, room, etc):_____
4. Level of security (check all that apply): ☐Minimal ☐Medium ☐High/Maximum
5. Respondent Name and Title: _____
6. Interviewer:_____ Date Completed: _____(MM/DD/YY)

Unit Characteristics

7. Unit is currently: ☐Under quarantine ☐Under medical isolation ☐ Other:_____
8. When did this unit start quarantine/isolation: _____(MM/DD/YY)
9. When was the last day a new detainee was added to this unit:_____(MM/DD/YY)
10. Number of detainees currently in the unit: _____
11. Full capacity of unit: _____
12. Unit type: ☐Individual cells ☐Dormitory (communal) housing
    a. How many beds per cell/room or dorm unit:_____
    b. How many detainees per cell/room or dorm unit:_____
    c. Are any cells currently shared in this unit? ☐Yes ☐No ☐ Unknown
    d. If dormitory unit, are the sleeping areas: ☐Cells or rooms with a door ☐Cubbies or other enclosure without a door ☐open dormitory ☐ Other, specify:_____
13. Number of levels: _____
14. How many of the following items are present in the common area within the unit:
    a. Toilets: _____
    b. Sinks/handwashing area: _____
    c. Showers:_____
    d. Phones:_____ ; Describe phone layout:_____
15. How many of the following items are present within each cell or dorm:
    a. Toilets: _____
    b. Sinks/handwashing area: _____
    c. Showers:_____

Facilities access among detainees in the unit

16. In the **past two weeks**, identify which facilities/items detainees have had access to:

	Access Level	**Individual vs. Shared Access**
Dining Area/Mess hall	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time
Recreation Area (inside common area)	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time
Recreation Area or yard (outside)	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time
Commissary	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time
Other:_____	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time

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17. Communal space
    a. How many detainees are allowed in the common space at a given time?_____
    b. How many different units share the common space?_____
    c. How often is the common space cleaned? And how?

How often?	How? (e.g. power washing, bleach, etc.)
☐ Between each group	
☐ Multiple times a day, but not between each group	
☐ Once a day	
☐ Other:_____	

    d. For how long each day is each group allowed in the common space?_____hours

18. Dining area
    a. Where are meals served? ☐ to each cell individually ☐ dining room or common space ☐ Other, specify:_____
    b. If dining area, how many different units share the dining area?_____

19. Is there an outdoor space associated with the unit? ☐Yes ☐No ☐ Unknown
    a. How many people are allowed outside at a time?_____
    b. How many different units share the outdoor space?_____
    c. For how long each day is a group allowed in the space?_____hours

Sanitation

20. In the **past two weeks**, which of the following items have detainees been provided (check all that apply):
☐Hand Sanitizer ☐Soap ☐Face Masks ☐ None ☐Unknown

21. In the **past two weeks**, have individuals on this tier been provided with individual hand sanitizer?
☐Yes ☐No ☐ Unknown

22. Where are the cleaning supplies located?
☐ In an area with free access ☐ Held by CO, and provided upon request ☐ Unknown
☐ Other, specify:_____

Work Units

23. In the **past two weeks**, have any detainees in this unit performed duties or services (e.g., work at the facility)? ☐Yes ☐No ☐Unknown

    d. If yes, do they work in, ☐Their unit only ☐ Their division only; no areas with other detainees ☐ Their division only; no areas with other detainees ☐ Other:_____
        i. Does the work unit contain detainees from other units?
        ☐Yes, at the same time/shift ☐Yes, same areas but different shifts ☐No ☐Unknown

24. In the **past two weeks**, which jobs have been performed by detainees in this unit?
☐Kitchen/meals ☐Library ☐Education ☐Laundry ☐Groundskeeping ☐Cleaning/Custodial ☐Unknown ☐Other, specify: _____

25. In which area or unit were these jobs performed in the **past two weeks**: _____

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Staffing

26. Are staff assigned or dedicated to work on this unit only? ☐Yes ☐No ☐Unknown
    e. If yes, for how long? _____
    f. [For corrections officers) How many shifts cover a 24 hour period? _____

27. On **an average day**, how many staff members are assigned to work in this unit? (extended time in this unit, or working with detainees from this unit) Total _____ (estimate if exact number not known); *by category:*
    a. Corrections: _____; do they work on other units? ☐Yes ☐No ☐Unknown
    b. Environmental/maintenance: _____; do they work on other units? ☐Yes ☐No ☐Unknown
    c. Admin: _____; do they work on other units? ☐Yes ☐No ☐Unknown
    d. Healthcare: _____ do they work on other units? ☐Yes ☐No ☐Unknown
    e. Other:_____ (specify job class:_____)
        i. do they work on other units? ☐Yes ☐No ☐Unknown

28. **On an average day**, how many staff members are within 6ft of the detainees for more than 10 minutes in this unit for their regular duties?
    Total _____ (estimate if exact number not known); *by category:*
    g. Corrections: _____
    h. Environmental/maintenance: _____
    i. Admin: _____
    j. Healthcare: _____
    k. Other:_____ (specify job class:_____)

Interviewer Notes:

_____

_____

_____

_____

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SARS-CoV-2 Cook County Questionnaire V24 rev 05/05/2020
(Correctional Facility Transmission Investigation)
Day 0/1 Form

CDC ID: _____

Administrative Information

1. Interviewer Name: First: _____Last:_____ Date: _____
2. Housing [*detainee*] or work [*staff*] location: Division: _____ Tier:_____ Other:_____
3. Date quarantine initiated: _____/_____/_____
4. At the unit, the number of current: Staff present:_____ Cells:_____ Detainees:_____
5. Interviewee: ☐ Detainee ☐ Staff

Demographic Information

6. Age: _____ Height:_____ (ft, in) Weight: _____ (lbs)
7. Ethnicity (select one): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Not Specified
8. Race (check all that apply): ☐ White ☐ Black ☐ Asian ☐ Am Indian/Alaska Nat ☐ Nat Hawaiian/Other PI ☐ Other, specify:_____ ☐ Unknown
9. Sex: ☐ Male ☐ Female

Symptoms

10. *Use no-touch thermometer to record current temperature*: _____°F
11. 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	___/___		☐	☐

12. For any of these symptoms, have you experienced them in the last two months? That means since _____(month).

Smoking Status *Note: Smoking is prohibited in the facility compound for all detainees.*

13. [*Staff only*] Do you currently smoke tobacco on a daily basis, less than daily, or not at all?
☐ Daily ☐ Less than daily ☐ Not at all ☐ Unknown
14. [*Staff only*] Do you currently vape or use electronic cigarettes on a daily basis, less than daily, or not at all?
☐ Daily ☐ Less than daily ☐ Not at all ☐ Unknown
15. In the past, have you smoked tobacco, used e-cigarettes or vaped?
☐ Daily ☐ Less than daily ☐ Not at all ☐ Unknown
16. [*If any use*] When was the last time? _____ (MM/YYYY)

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SARS-CoV-2 Cook County Questionnaire V24 rev 05/05/2020
(Correctional Facility Transmission Investigation)
Day 0/1 Form

CDC ID: _____

Past Medical History

17. Please provide pre-existing medical conditions (complete regardless of age):

Condition	Response	If YES, specify
Health conditions that cause breathing problems?	☐Yes ☐No ☐Unk/DK/Ref	☐ Asthma ☐ COPD (chronic obstructive pulmonary disease) ☐ Emphysema ☐ Lung Cancer ☐ Sleep Apnea ☐ Other, specify:_____
Diabetes or problems with your blood sugar?	☐Yes ☐No ☐Unk/DK/Ref	☐ Type 1 ☐ Type 2 Are you taking insulin? ☐ Yes ☐ No
Heart problems or high blood pressure?	☐Yes ☐No ☐Unk/DK/Ref	☐ Congenital heart abnormalities ☐ Coronary artery disease ☐ Heart failure ☐ High cholesterol (Hyperlipidemia) ☐ High blood pressure (Hypertension) ☐ Heart attack (Myocardial infarction) ☐ Other, specify_____
Kidney problems?	☐Yes ☐No ☐Unk/DK/Ref	☐ Chronic kidney disease ☐ Dialysis ☐ End-stage renal disease ☐ Other, specify: _____
Liver problems?	☐Yes ☐No ☐Unk/DK/Ref	☐ Cirrhosis ☐ End-stage liver disease ☐ Hepatitis B ☐ Hepatitis C ☐ Other, specify:_____
A disease, medication, or condition that weakens your immune system?	☐Yes ☐No ☐Unk/DK/Ref	☐ Chemotherapy ☐ HIV/AIDS ☐ Lupus ☐ Steroids ☐ Other, specify:_____
Learning or memory problems or history of head injury?	☐Yes ☐No ☐Unk/DK/Ref	☐ Dementia/Alzheimer's ☐ Neurodevelopmental Disorder ☐ Stroke ☐ Traumatic Brain Injury ☐ Other, specify:_____
Do you have other health/medical problems you would like me to know about?	☐Yes ☐No ☐Unk/DK/Ref	Specify:_____

18. Have you been assigned to any other Divisions or Tiers in the last 2 months? ☐ Yes ☐ No
    If yes, how many? _____
    If known, specify Division(s) and Tier(s):_____

SARS-CoV-2 testing

19. Have you ever been offered a test for coronavirus? ☐ Yes ☐ No ☐ Refused ☐ Unknown

    a. If yes, have you been tested for coronavirus? ☐ Yes ☐ No

        i. Date of most recent test:_____(MM/DD/YYYY)

        ii. Did you experience any symptoms at the time you were tested? ☐ Yes ☐ No

        iii. Result of most recent test: ☐ Positive ☐ Negative ☐ Pending ☐ Indeterminate ☐ Don't know ☐ Other, specify: _____

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SARS-CoV-2 Cook County Questionnaire V24 rev 5/05/2020
(Correctional Facility Transmission Investigation)
Day 3/4 Form

CDC ID: _____

Administrative Information

1. Interviewer Name: First: _____Last:_____ Date: _____/____/_____
2. Housing [*detainee*] location: Division: _____ Tier:_____ Other:_____
3. Date quarantine initiated: _____/_____/_____
4. At the tier, the number of current: Staff present:_____ Cells:_____ Detainees:_____
5. Interviewee: ☐ Detainee

Symptoms

6. *Use no touch thermometer to record current temperature*: _____°F
7. 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	___/___		☐
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	___/___		☐

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SARS-CoV-2 Cook County Questionnaire V24 rev 5/05/2020
(Correctional Facility Transmission Investigation)
Day 14 Form

CDC ID: _____

Administrative Information

1. Interviewer Name: First: _____Last:_____ Date: _____/____/_____
2. Housing [*detainee*] location: Division: _____ Tier:_____ Other:_____
3. Date quarantine initiated: _____/_____/_____
4. At the unit, the number of current: Staff present:_____ Cells:_____ Detainees:_____
5. Interviewee: ☐ Detainee

Symptoms

6. *Use no touch thermometer to record current temperature*: _____°F
7. 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?
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	___/___		☐

Form Approved
OMB No. 0920-1011
Exp. Date 1/31/2023

Illinois Department of Public Health
Request for COVID-19 / Respiratory Testing

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Request For COVID-19 / Respiratory Testing

Print using upper case letters.
Do not fax this form to the lab.

SUBMITTER INFORMATION

AUTHORIZATION CODE

SUBMITTER PHONE NUMBER - -

Fax Number for Reporting Result* (see instructions) - -

FAX REQUESTED ○ Yes ○ No

SUBMITTER'S NAME

STREET ADDRESS (Include apartment/suite number)

CITY | STATE | ZIP CODE

CONTACT PERSON

PHYSICIAN NAME

PATIENT INFORMATION

PATIENT'S FIRST NAME | BIRTHDATE / / | AGE

PATIENT'S LAST NAME | MEDICAID IDENTIFICATION NUMBER | PREGNANT ○ Yes ○ No ○ UNK

PATIENT'S IDENTIFICATION NUMBER

RACE
○ White ○ Asian/Pacific Islander
○ African American/Black ○ Other
○ Native American ○ Unknown

ETHNICITY
○ Hispanic
○ Non-Hispanic

SEX
○ Male
○ Female

STREET ADDRESS (Include apartment/suite number)

CITY | STATE | ZIP CODE

CELL NUMBER - -

TEST INFORMATION

DATE COLLECTED / / | TIME COLLECTED : | SYMPTOM ONSET DATE / /

APPROVED TESTING CRITERIA — ONLY ONE (1) SAMPLE PER FORM

TESTS REQUESTED
○ COVID-19 ○ Arbovirus Panel
○ Respiratory Panel ○ Influenza

SPECIMEN SOURCE TYPE
○ Nasopharyngeal Swab ○ Nasal Aspirate ○ Nasopharyngeal wash/aspirate ○ Other
○ Pharyngeal Swab ○ Nasal Swab ○ Broncheoalveolar Lavage "BAL"
○ Oropharyngeal Swab ○ Sputum ○ Lower Respiratory Tract Aspirates

LAB USE ONLY

Specimen Number Area Below

Reset

55836

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SARS-CoV-2 Correctional Facility Assessment
V3 rev 5/06/2020

(Correctional Facility Transmission Investigation)

Unit Survey [Complete this survey for each unit of the facility assessed.]

1. Facility Name:_____
2. Unit Name: _____
3. Location (building, floor, room, etc):_____
4. Level of security (check all that apply): ☐Minimal ☐Medium ☐High
5.
6. Respondent Name and Title: _____
7. Interviewer:_____ Date Completed: _____(MM/DD/YY)

Unit Characteristics

8. Number of detainees currently in the unit: _____
9. Full capacity of unit: _____
10. Unit type: ☐Single cells ☐Dormitory (communal) housing
    a. How many beds per room:_____
    b. If dormitory unit, are the sleeping areas: ☐Cells or rooms with a door ☐Cubbies or other enclosure without a door ☐open dormitory ☐ Other, specify:_____
11. Number of floors: _____
12. How many of the following items are present within the unit:
    a. Toilets: _____
    b. Sinks/handwashing area: _____
    c. Showers:_____

Facilities access among detainees in the unit

13. In the past two weeks, identify which facilities/items detainees have had access to and who uses the facilities/items.

	Access Level	**Individual vs Shared**
Toilets	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time
Showers	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time
Dining Area	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time
Recreation Area (inside common area)	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time
Recreation Area or yard (outside)	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time
Phone Access	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time
Computer Access	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time
Commissary	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time
Library	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time
Facility Healthcare Clinic	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time

SARS-CoV-2 Correctional Facility Assessment
V3 rev 5/06/2020

(Correctional Facility Transmission Investigation)

Other:_____	☐All the time ☐Restricted ☐None ☐Unknown	☐Cell only ☐Unit only ☐Multiple units different time ☐Multiple units same time

Sanitation

14. In the last two weeks, which of the following items have detainees been provided (check all that apply):
    ☐Hand Sanitizer ☐Soap ☐Face Masks ☐ None ☐Unknown
    a. If masks are provided, how often are they replaced or washed?_____
    b. If masks are provided, are they typically being worn:
    ☐Always ☐Only outside of cell ☐Only outside of dorm
    c. If soap is provided, is it unlimited? ☐Yes ☐No ☐Unknown
        i. If no, quantity?_____
15. Could a detainee in this unit wash their hands at all times of the day: ☐Yes ☐No ☐Unknown

Work Units

16. Do any detainees in this unit perform duties or services (e.g. work at the facility)? ☐Yes ☐No ☐Unknown
    a. If yes, do they work in, ☐Their unit only ☐ Other common areas ☐ Both
        i. [*if in other common areas*] Do they work with detainees from other units?
        ☐Yes, at the same time/shift ☐Yes, same areas but different shifts ☐No ☐Unknown

17. Which jobs are performed by detainees in this unit? ☐Kitchen ☐Library ☐Education ☐Laundry ☐Groundskeeping ☐Unknown ☐Other, specify: _____

Staffing

18. How many staff members are assigned to work in this unit? (extended time in this unit, or working with detainees from this unit) Total _____ (estimate if exact number not known); *by category:*
    a. Corrections: _____
    b. Environmental/maintenance: _____
    c. Admin: _____
    d. Healthcare: _____
    e. Other:_____ (specify job class:_____)

19. How many staff members potentially are within 6ft of the detainees for any length of time in this unit for their regular duties? Total _____ (estimate if exact number not known); *by category:*
    a. Corrections: _____
    b. Environmental/maintenance: _____
    c. Admin: _____
    d. Healthcare: _____
    e. Other:_____ (specify job class:_____)

SARS-CoV-2 Correctional Facility Assessment
V3 rev 5/06/2020

(Correctional Facility Transmission Investigation)

Coronavirus

20. How many suspected (individuals with fever, cough, or shortness of breath) or confirmed COVID-19 cases have been identified in this unit since January 2020? (Write "unknown" if value not known).

	Among Detainees	Among Staff
Suspected COVID-19 Cases (PUI)		
Confirmed COVID-19 Cases		
Suspected Hospitalized COVID-19 Cases (PUI)		
Confirmed Hospitalized COVID-19 Cases		
Any Death		
COVID-19-related Deaths		

21. When was the first positive COVID-19 case identified at this unit (staff or detainee)?
_____ (mm/dd/yyyy)

22. When was the most recent positive COVID-19 case identified at this unit (staff or detainee)?
_____ (mm/dd/yyyy)

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SARS-CoV-2 Louisiana Questionnaire V3 rev 05/04/2020

(Correctional Facility Transmission Investigation)

Day 0/1 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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SARS-CoV-2 Louisiana Questionnaire V3 rev 05/04/2020
(Correctional Facility Transmission Investigation)
Day 0/1 Form

CDC ID: _____

Administrative Information

1. Interviewer Name: First: _____Last:_____ Date: _____/____/_____
2. Housing location: Dorm: _____Other:_____
3. Sleeping location: ☐☐ top bunk ☐☐ bottom bunk
1. Date quarantine initiated in dorm: _____/_____/_____
2. At the dorm, the number of current: Staff present:_____ Cells:_____ Detainees:_____

Demographic Information

3. Age: _____ Height:_____ (ft, in) Weight: _____ (lbs)
4. Ethnicity (select one): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Not Specified
5. Race (check all that apply): ☐ White ☐ Black ☐ Asian ☐ Am Indian/Alaska Nat ☐ Nat Hawaiian/Other PI ☐ Other, specify:_____ ☐ Unknown
6. Sex: ☐ Male ☐ Female

Symptoms

7. *Use no-touch thermometer to record current temperature*: _____°F
8. 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	___/___		☐	☐

NOTE: For any of these symptoms, have you experienced them in the last two months? That means since _____(month).

Smoking Status

Note: Smoking is prohibited in the facility compound for all detainees.

9. In the past, have you smoked tobacco on a daily basis, less than daily, or not at all?
   ☐ Daily ☐ Less than daily ☐ Not at all ☐ Unknown
10. [*If any use*] When was the last time you used tobacco? _____ (MM/YYYY)

11. In the past, have you vaped or used electronic cigarettes on a daily basis, less than daily, or not at all?
   ☐ Daily ☐ Less than daily ☐ Not at all ☐ Unknown
12. [*If any use*] When was the last time you used electronic cigarettes or vaping? _____ (MM/YYYY)

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SARS-CoV-2 Louisiana Questionnaire V3 rev 05/04/2020
(Correctional Facility Transmission Investigation)
Day 0/1 Form

CDC ID: _____

Past Medical History

13. Please provide pre-existing medical conditions (complete regardless of age):

Condition	Response	If YES, specify
Health conditions that cause breathing problems?	☐Yes ☐No ☐Unk/DK/Ref	☐ Asthma ☐ COPD (chronic obstructive pulmonary disease) ☐ Emphysema ☐ Lung Cancer ☐ Sleep Apnea ☐ Other, specify:_____
Diabetes or problems with your blood sugar?	☐Yes ☐No ☐Unk/DK/Ref	☐ Type 1 ☐ Type 2 Are you taking insulin? ☐ Yes ☐ No
Heart problems or high blood pressure?	☐Yes ☐No ☐Unk/DK/Ref	☐ Congenital heart abnormalities ☐ Coronary artery disease ☐ Heart failure ☐ High cholesterol (Hyperlipidemia) ☐ High blood pressure (Hypertension) ☐ Heart attack (Myocardial infarction) ☐ Other, specify_____
Kidney problems?	☐Yes ☐No ☐Unk/DK/Ref	☐ Chronic kidney disease ☐ Dialysis ☐ End-stage renal disease ☐ Other, specify: _____
Liver problems?	☐Yes ☐No ☐Unk/DK/Ref	☐ Cirrhosis ☐ End-stage liver disease ☐ Hepatitis B ☐ Hepatitis C ☐ Other, specify:_____
A disease, medication, or condition that weakens your immune system?	☐Yes ☐No ☐Unk/DK/Ref	☐ Chemotherapy ☐ HIV/AIDS ☐ Lupus ☐ Steroids ☐ Other, specify:_____
Learning or memory problems, stroke, seizure disorder, or history of head injury?	☐Yes ☐No ☐Unk/DK/Ref	☐ Dementia/Alzheimer's ☐ Neurodevelopmental Disorder ☐ Stroke ☐ Traumatic Brain Injury ☐ Other, specify:_____
Do you have other health/medical problems you would like me to know about?	☐Yes ☐No ☐Unk/DK/Ref	Specify:_____

Medication Use

14. **Currently,** what types of medications do you take for underlying conditions, including prescriptions & inhalers?
    Do you take any medications for high blood pressure?
    How about for infections caused by fungus, bacteria, or viruses? *(If yes, ask questions to fill in table below)*
    How about any medications that may weaken your immune system and ability to fight infections? These medications are often used to treat autoimmune disorders or inflammation. *(If yes, ask questions to fill in table below)*
    Do you use an inhaler? *(If yes, ask questions to fill in table below)*
    Any other medications you may have forgotten? *(If yes, ask questions to fill in table below)*

Medication Name	Indication

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CDC ID: _____

Facility Questions

15. At this facility, how many different people are you in contact with (<6 ft) on an average day?_____
16. 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

17. How many times per day do you wash or sanitize your hands (on average)?_____

18. When you wash your hands, do you use (check all that apply): ☐ Soap & Water ☐ Hand sanitizer ☐ Water alone ☐ Don't wash hands ☐ Unknown

19. 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

20. Have you worn a mask at the facility in the last 2 weeks? ☐ Yes ☐ No ☐ Unknown
    a. If yes, what type of mask (check all that apply)? ☐ Cloth ☐ Surgical ☐ Unknown ☐ Other, specify:_____
    b. When around others (<6 ft), how often do you wear a mask?
    ☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Unknown
    c. When outside of your cell, how often do you wear a mask?
    ☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Unknown

Movement and Activity History

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

Activity	Answer	Where?	When?
…traveled outside your dorm?	☐ Yes ☐ No		
...traveled outside the facility?	☐ Yes ☐ No		
…gone to court? (Excludes video court)	☐ Yes ☐ No		
…had a work assignment off your dorm?	☐ Yes ☐ No		

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Day 0/1 Form

CDC ID: _____

22. Have you been assigned to any other dorms in the last 2 months? ☐ Yes ☐ No
    a. If yes, how many? _____
    b. If known, specify dorm(s):_____

Potential Exposure

23. 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

24. Have you ever been offered a test for coronavirus? ☐ Yes ☐ No ☐ Refused ☐ Unknown

    a. If yes, have you been tested for coronavirus? ☐ Yes ☐ No

        i. Date of most recent test:_____(MM/DD/YYYY)

        ii. Did you experience any symptoms at the time you were tested? ☐ Yes ☐ No

        iii. Result of most recent test: ☐ Positive ☐ Negative ☐ Pending ☐ Indeterminate ☐ Don't know ☐ Other, specify: _____

Notes:

_____
_____
_____
_____

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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_____

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

CDC ID: _____

Administrative Information

1. Interviewer Name: First: _____Last:_____ Date: _____/____/_____
2. Housing location: Dorm:_____ Other:_____
3. Sleeping location: ☐☐ top bunk ☐☐ bottom bunk
4. Date quarantine initiated in dorm: _____/_____/_____
5. At the dorm, the number of current: Staff present:_____ Cells:_____ Detainees:_____

Symptoms

6. *Use no touch thermometer to record current temperature*: _____°F
7. 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	___/___		☐
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

8. 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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SARS-CoV-2 Louisiana Questionnaire V1 rev 5/20/2020
(Correctional Facility Transmission Investigation)
Day 14 Form

CDC ID: _____

Interviewee Information

Booking or JDE Number:_____

Specimen ID

First:_____ Last:_____

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

CDC ID_____

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SARS-CoV-2 Louisiana Questionnaire V1 rev 5/20/2020
(Correctional Facility Transmission Investigation)
Day 14 Form

CDC ID: _____

Administrative Information

1. Interviewer Name: First: _____Last:_____ Date: _____/____/_____
2. Housing location: Dorm: _____Other:_____
3. Sleeping location: ☐ top bunk ☐ bottom bunk
4. Interviewee: ☐ Detainee

Symptoms

5. *Use no touch thermometer to record current temperature*: _____°F
6. Since we last tested you, have you experienced any of the following symptoms*?*

	Symptom Present Last 2 Weeks?	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	___/___		☐
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	___/___		☐

Movement and Activity History

7. Since we last tested you, have you ….?

Activity	Answer	Frequency
… traveled outside your dorm?	☐ Yes ☐ No	☐ Daily ☐ A few times a week ☐ Once a week
… traveled outside the facility?	☐ 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
… gone anywhere else?	☐ Yes ☐ No	If so, where: _____

Potential Exposure

8. Since we last tested 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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COVID-19 Test Request Form

COVID-19 Test Request Form

Do you have a PUI Number for this request?

- ○ Yes
- ○ No

2nd Unique ID / PUI # *

LA2020

PUI # should start with "LA2020" and include at least 4 additional characters.

2nd unique ID entered above must be present on sample

Hospitalization Status and Symptoms

This patient is: (check all that apply) *

- ☐ Hospitalized?
- ☐ Admitted to ICU?
- ☐ Intubated (Mechanical Vent)?
- ☐ ER Visit Only?
- ☐ None of the Above

Symptoms Reported *

- ☐ Fever, include temperature below
- ☐ Sore Throat
- ☐ Chills
- ☐ Abdominal Pain
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Headache
- ☐ Runny Nose
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Muscle Aches

- [ ] ARDS
- [ ] Abnormal Chest X-Ray
- [ ] Pneumonia, specify below
- [ ] Other, specify below
- [ ] None of the Above

Has testing been done to rule out other respiratory illnesses? *

- ○ Yes
- ○ No

Influenza? *

- ○ Not Done
- ○ Negative
- ○ Positive
- ○ Pending

Respiratory Virus Panel? *

- ○ Not Done
- ○ Negative
- ○ Positive
- ○ Pending

Blood Cultures? *

- ○ Not Done
- ○ Negative
- ○ Positive
- ○ Pending

Other Tests? *

- ○ Not Done
- ○ Negative

- ○ Positive
- ○ Pending

Does the patient have any comorbid conditions? *

- ○ Yes
- ○ No

Step 1 of 5

< PREVIOUS CONTINUE >