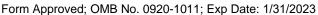
Form Approved OMB No. 0920-1011 Exp. Date 1/31/2023

SARS-CoV-2 Correctional Facility Assessment V7 rev 5/11/2020

(Correctional Facility Transmission Investigation)





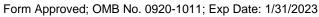
SARS-CoV-2 Correctional Facility Assessment V7 rev 5/11/2020

(Correctional Facility Transmission Investigation)

1.	Facility	y Name:		
2.	Unit Na	lame:		
3.	Locatio	on (building, floor, room, etc):		
4.	Level o	of security (check all that apply): 🔲	Minimal Medium l	High/Maximum
5.	Respor	ndent Name and Title:		
6.	Intervi	iewer:	Date Completed:	(MM/DD/YY)
nit Ch	naracter	ristics		
		currently: Under quarantine	Under medical isolation	Other:
		did this unit start quarantine/isolati		
		n was the last day a new detainee wa		
		er of detainees currently in the unit:		
		pacity of unit:		
		ype: Individual cells Dormitory	(communal) housing	
	a.	How many beds per cell/room or o	dorm unit:	
	b.	How many detainees per cell/roor	m or dorm unit:	
	c.	Are any cells currently shared in th	nis unit? 🔲 Yes 🔲 No 🔲 Un	known
	d.	If dormitory unit, are the sleeping	areas: Cells or rooms with	n a door \square Cubbies or other enclosur
		without a dooropen dormitory	/ Other, specify:	
13.	Numbe	er of levels:		
14.	How m	nany of the following items are pres	ent in the common area with	in the unit:
	a.	Toilets:		
	b.	Sinks/handwashing area:	_	
	c.	Showers:		
	d.	Phones:; Describe pho	ne layout:	
15.	How m	nany of the following items are pres	ent within each cell or dorm:	
		Toilets:		
	b.	Sinks/handwashing area:	-	

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	Cell only Unit only Multiple units
	None Unknown	different time Multiple units same time
Recreation Area	All the time Restricted	Cell only Unit only Multiple units
(inside common area)	None Unknown	different time Multiple units same time
Recreation Area or	All the time Restricted	Cell only Unit only Multiple units
yard (outside)	None Unknown	different time Multiple units same time
Commissary	All the time Restricted	Cell only Unit only Multiple units
	None Unknown	different time Multiple units same time
Other:	All the time Restricted	Cell only Unit only Multiple units
	None Unknown	different time Multiple units same time



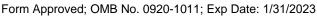


SARS-CoV-2 Correctional Facility Assessment V7 rev 5/11/2020

(Correctional Facility Transmission Investigation)

17. Communa	al space	
a. H	ow many detainees are allowed in the common space a	at a given time?
b. H	ow many different units share the common space?	
c. H	ow 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. F	or how long each day is each group allowed in the comr	non space?hours
18. Dining are		
	Where are meals served? to each cell individually	dining room or common space
U	ther, specify: dining area, how many different units share the dining	araa
υ. <u>II</u>	diffing area, flow many different units share the diffing	alea!
19. Is there a	n outdoor space associated with the unit? Yes No	Unknown
	ow many people are allowed outside at a time?	
b. H	ow many different units share the outdoor space?	
c. F	or how long each day is a group allowed in the space?_	hours
<u>Sanitation</u>	are a control to the College College Control to the control to the College Col	and the second of the Land of
	st two weeks, which of the following items have detained	
папа з	Sanitizer Soap Face Masks None	eOnknown
21 In the na s	st two weeks, have individuals on this tier been provide	d with individual hand sanitizer?
	No Unknown	a with marviada hand sameleer.
22. Where ar	e the cleaning supplies located?	
☐ In an area	with free access Held by CO, and provided upon red	quest 🗌 Unknown
Other, spe	ecify:	
Work Units		
	st two weeks, have any detainees in this unit performed	d duties or services (e.g., work at the
facility)?	YesNoUnknown	
d If	yes, do they work in, Their unit only Their divisio	un only no areas with other detaineds
u. 11	Their division only; no areas with other detainees	• 1
L	i. Does the work unit contain detainees from other	
	Yes, at the same time/shift Yes, same areas by	
24. In the pas	st two weeks, which jobs have been performed by detail	inees in this unit?
Kitchen/m		
Unknown		
25. In which a	area or unit were these jobs performed in the past two	weeks:

3

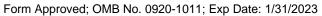




SARS-CoV-2 Correctional Facility Assessment V7 rev 5/11/2020

(Correctional Facility Transmission Investigation)

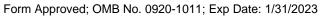
Staffing	
26. Are sta	ff assigned or dedicated to work on this unit only? Yes No Unknown
	If yes, for how long?
f.	[For corrections officers) How many shifts cover a 24 hour period?
	average day, how many staff members are assigned to work in this unit? (extended time in this unit, king with detainees from this unit) Total (estimate if exact number not known); by ry:
	Corrections:; do they work on other units?YesNoUnknown
b.	Environmental/maintenance:; do they work on other units?YesNoUnknown
c.	Admin:; do they work on other units?YesNoUnknown
d.	Healthcare: do they work on other units? Yes No Unknown
e.	Other:(specify job class:) i. do they work on other units?
28. On an a	average day, how many staff members are within 6ft of the detainees for more than 10 minutes in
	it for their regular duties?
	ral (estimate if exact number not known); by category:
	Corrections:
h.	Environmental/maintenance:
i.	Admin:
j.	Healthcare:
•	Other:(specify job class:)
Interviewer No	tes:





SARS-CoV-2 Cook County Questionnaire V24 rev 05/05/2020

	•			CDC II):
Administrative Information					
1. Interviewer Name: First:	Last:]	Date:		
2. Housing [detainee] or work [staff] location: Di		O ₁	ther:		
3. Date quarantine initiated://	_				
4. At the unit, the number of current: Staff presen	t: Cells:	I	Detainees:		_
5. Interviewee: Detainee Staff					
Demographic Information					
6. Age: Height: (ft, in)	Weight:	(lbs)			
7. Ethnicity (select one): Hispanic/Latino	☐ Non-Hispanic/	Latino []	Not Specifie	ed	
8. Race (check all that apply): White B			ka Nat 🔲 I	Nat Hawaiiai	n/Other PI
	y: Un	ıknown			
9. Sex: Male Female					
C					
Symptoms 10 H		O.E.			
10. Use no-touch thermometer to record current te					
11. In the last two weeks, have you experienced an	ly of the following syn		T	I	
	Symptom Present	Onset			Last 2
	Last 2 Weeks?	Date	# of Days	Ongoing?	Months?
		(mm/dd)			
Fever $> 100.4^{\circ} \text{F} (38^{\circ} \text{ C})$	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	Yes No Unk	/			
Loss of smell Complete Partial	Yes No Unk	/			
Other, specify:	Yes No Unk	/			
12. For any of these symptoms, have you experience	ced them in the last tw	o months? Th	at means si	nce	(month).
Smoking Status Note: Smoking is prohibited in the					
13. [Staff only] Do you currently smoke tobacco or			t at all?		
Daily Less than daily Not	—				
14. [Staff only] Do you currently vape or use electr			than daily,	or not at all	!
	at all Unknown	n			
15. In the past, have you smoked tobacco, used e-c					
<u> </u>	t at all Unknow				
16. [If any use] When was the last time?	(MM/YYY	(Y)			





Past Medical History

health/medical problems you

would like me to know about?

SARS-CoV-2 Cook County Questionnaire V24 rev 05/05/2020

(Correctional Facility Transmission Investigation) Day 0/1 Form

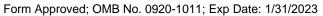
17. Please provide pre-existing medical conditions (complete regardless of age):

Unk/DK/Ref

CDC ID	

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

8. 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?						
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	e you were tested? Yes No					
iii. Result of most recent test: Positive Negative Pending Indeterminate Don't know Other, specify:						





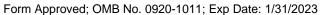
SARS-CoV-2 Cook County Questionnaire V24 rev 5/05/2020

(Correctional Facility Transmission Investigation) **Day 3/4 Form**

	•		CDC ID:
Ad	ministrative 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		
$\mathbf{S}\mathbf{y}$	mptoms		
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	☐Yes ☐No ☐Unk	/		
Loss of smell Complete Partial	☐Yes ☐No ☐Unk	/		
Other, specify:	☐Yes ☐No ☐Unk	/		





Sore throat

Nausea

Vomiting Headache

Loss of taste

Loss of smell

Other, specify:

Abdominal pain

Shortness of breath (dyspnea)

Diarrhea (≥3 loose stools/24hr period)

Cough (new onset or worsening of chronic cough)

☐ Complete

☐ Complete

Partial

Partial

SARS-CoV-2 Cook County Questionnaire V24 rev 5/05/2020

(Correctional Facility Transmission Investigation)

Day 14	Form	
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				CDC I	D:
	<u>lministrative Information</u>				
1.	Interviewer Name: First:La	ast:	Date:	/ /	
2.	Housing [detainee] location: Division: Tier:	Other:			
3.	Date quarantine initiated:/				
4.	At the unit, the number of current: Staff present:	Cells:	Detainees	:	
	Interviewee: Detainee				
6.	mptoms Use no touch thermometer to record current temperal In the last two weeks, have you experienced any of the second current temperal in the last two weeks.				
		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	/		

☐Yes ☐No ☐Unk ☐Yes ☐No ☐Unk

☐Yes ☐No ☐Unk ☐Yes ☐No ☐Unk

☐Yes ☐No ☐Unk ☐Yes ☐No ☐Unk

Yes No Unk

☐Yes ☐No ☐Unk

☐Yes ☐No ☐Unk ☐Yes ☐No ☐Unk

☐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

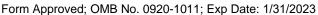
Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may 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)

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Request For COVID-19 / Respiratory Testing

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

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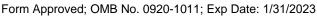


SARS-CoV-2 Correctional Facility Assessment V3 rev 5/06/2020

(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 Ti	tle:					
7.	Interviewer:	Date Comp	oleted:(MM/DD/YY)				
Unit Ch	<u>aracteristics</u>						
8.	Number of detainees curr	rently in the unit:					
9.	Full capacity of unit:						
10.	Unit type: Single cells	Dormitory (communal) hous	ing				
	a. How many beds p	oer room:					
			s or rooms with a door Cubbies or other				
		t a dooropen dormitory	Other, specify:				
	Number of floors:	-					
12.		ng items are present within the	unit:				
	a. Toilets:						
	b. Sinks/handwashii						
	c. Showers:						
Facilitie	es access among detainees	in the unit					
			ainees have had access to and who uses the				
13.	facilities/items.	entity which facilities/items det	annees have had access to and who uses the				
		Access Level	Individual vs Shared				
	Toilets	All the time Restricted	Cell only Unit only Multiple units				
		None Unknown	different time Multiple units same time				
	Showers	All the time Restricted	Cell only Unit only Multiple units				
		None Unknown	different time Multiple units same time				
	Dining Area	All the time Restricted	Cell only Unit only Multiple units				
	8 ou	None Unknown	different time Multiple units same time				
	Recreation Area	All the time Restricted	Cell only Unit only Multiple units				
	(inside common area)	None Unknown	different time Multiple units same time				
	Recreation Area or	All the time Restricted	Cell only Unit only Multiple units				
	yard (outside)	None Unknown	different time Multiple units same time				
	Phone Access	All the time Restricted	Cell only Unit only Multiple units				
		None Unknown	different time Multiple units same time				
	Computer Access	All the time Restricted	Cell only Unit only Multiple units				
		☐None ☐Unknown	different time Multiple units same time				
	Commissary	All the time Restricted	Cell only Unit only Multiple units				
		☐None ☐Unknown	different time Multiple units same time				
	Library	All the time Restricted	Cell only Unit only Multiple units				
		None Unknown	different time Multiple units same time				
	Facility Healthcare	All the time Restricted	Cell only Unit only Multiple units				
	Clinic	None Unknown	different time Multiple units same time				

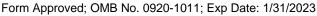




SARS-CoV-2 Correctional Facility Assessment V3 rev 5/06/2020

(Correctional Facility Transmission Investigation)

	Other:	All the time Restricted	Cell only Unit only Multiple units
		None Unknown	different time Multiple units same time
Sanitatio	nn		
	n the last two weeks, wh	Soap Face Masks	detainees been provided (check all that apply): None Unknown
			ed or washed?
		ided, are they typically being w	
		Only outside of cellOnly	
		d, is it unlimited?	JUNKNOWN
15 (-		s of the day: Yes No Unknown
15. (could a detaillee ill tills t	ant wash then hands at an time.	of the day.
Work Ur	nits_		
16. (a. If yes, do they wo i. [<i>if in othe</i>	ork in,Their unit only Oth er common areas] Do they work	e.g. work at the facility)?
[d by detainees in this unit? Ulunknown Other, specify: _	Kitchen Library Education Laundry
Staffing			12 /
		_	it? (extended time in this unit, or working with act number not known); by category:
,	a. Corrections:		act number not known, by category.
		naintenance:	
	c. Admin:		
		-	
	d. Healthcare:		1
	e. Other:	(specify job class:)
19. I	How many staff member	s potentially are within 6ft of th	e detainees for any length of time in this unit for
	•	•	number not known); by category:
	a. Corrections:		,, , , , , , , , , , , , , , , , , , , ,
	b. Environmental/m	naintenance:	
	c. Admin:		
	d. Healthcare:		
)





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)



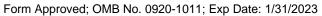
Form Approved; OMB No. 0920-1011; Exp Date: 1/31/2023

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.

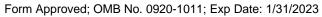


CDC ID: _____



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

Administrative Information						
1. Interviewer Name: First:	Last:	Date: _	/	/		
2. Housing location: Dorm:Other:						
3. Sleeping location: top bunk bott						
1. Date quarantine initiated in dorm:/			ъ.			
2. At the dorm, the number of current: Staff present: Cells: Detainees:						
Demographic Information						
3. Age: Height: (ft, in) 4. Ethnicity (select one): Hispanic/Latino	<u>Weight: (lbs</u>					
4. Ethnicity (select one): Hispanic/Latino	Non-Hispanic/Lat	tino 🔲 l	Not Specifie	ed		
5. Race (check all that apply): White BI	lack Asian Am I	ndian/Alasl	ka Nat ∐ I	Nat Hawaiia	n/Other PI	
U Other, specify	7: Unkn	own				
6. Sex: Male Female						
Symptoms						
7. Use no-touch thermometer to record current te	mperature:°F					
8. In the last two weeks, have you experienced an	y of the following sympt	toms?				
	G 4 D 4	Onset			Last 2	
	Symptom Present Last 2 Weeks?	Date	# of Days	Ongoing?	Months?	
		(mm/dd)			Widitis.	
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	☐Yes ☐No ☐Unk	/				
Loss of smell	☐Yes ☐No ☐Unk	/				
Other, specify:	☐Yes ☐No ☐Unk	/_				
NOTE: For any of these symptoms, have you expen	rienced them in the last to	wo months'	? That mear	ns since	(month).	
Smoking Status Note: Smoking is prohibited in the						
9. In the <u>past</u> , 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)						
10. [1] they mad in the fact time you also tooleed (19119) 1 1 1 1)						
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		•	•			
2. [If any use] When was the last time you used electronic cigarettes or vaping? (MM/YYYY)						

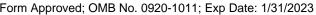




SARS-CoV-2 Louisiana Questionnaire V3 rev 05/04/2020

CDC	ID.	
	117:	

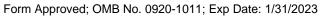
Past Medical History						
13. Please provide pre-existing me						
Condition	Response	If YES, specify				
Health conditions that cause breathing problems?	☐Yes ☐No ☐Unk/DK/Re	Other, specify:				
Diabetes or problems with your blood sugar?	Yes No Unk/DK/Re	Type 1 Type 2 Are you taking insulin? Yes No				
Heart problems or high blood pressure?	☐Yes ☐No ☐Unk/DK/Re	High blood pressure (Hypertension) Heart attack (Myocardial infarction) Other, specify				
Kidney problems?	☐Yes ☐No ☐Unk/DK/Re	Other, specify:				
Liver problems?	Yes No Unk/DK/Re					
A disease, medication, or condition that weakens your immune system?	Yes No Unk/DK/Re					
Learning or memory problems, stroke, seizure disorder, or history of head injury?	☐Yes ☐No ☐Unk/DK/Re	Other, specify:				
Do you have other health/medical problems you would like me to know about?	☐Yes ☐No ☐Unk/DK/Re	f 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	Ind	ication				





Form Approved; OMB No. 0920-1011; Exp Date: 1/31/2023 SARS-CoV-2 Louisiana Questionnaire V3 rev 05/04/2020

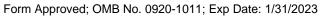
			CDC ID:
Facility Overtions			
Facility Questions 15. At this facility, how many different p 16. In the last two weeks, have you had h ☐ Yes ☐ No ☐ Unknown If yes, how many times per day (1 times)	nandcuffs put on? (*C	Other than for this survey*)	
Sanitation Levels 17. How many times per day do you was	h or sanitize your han	ds (on average)?	
18. When you wash your hands, do you u	use (check all that app	ly): Soap & Water F Don't wash hands	Hand sanitizer Water alone Unknown
19. When do you wash your hands (chec After coughing or sneezing After touching dirty laundry	After touching another		ning a shared phone the bathroom
20. Have you worn a mask at the facility a. If yes, what type of mask (check a		☐ Yes ☐ No ☐ Cloth ☐ Surgi ☐ Other, specify:	Unknown cal Unknown
c. When outside of your cell, how of	Sometimes	☐ Never ☐ Unkn	
Movement and Activity History 21. While staying in this facility, have yo	ou done any of the foll	owing activities in the last t	wo 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		





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

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?	
a. If yes, have you been tested for coronavirus?	
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:	



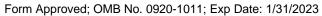


SARS-CoV-2 Louisiana Questionnaire V1 rev 5/04/2020

(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)	ii
CDC ID	

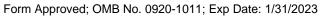
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SARS-CoV-2 Louisiana Questionnaire V1 rev 5/04/2020

1				CD	C ID:
	ministrative Information Interviewer Name: First:	Last:	Date	: /	/
	Housing location: Dorm: Other:				
	Sleeping location: top bunk botto				
	Date quarantine initiated in dorm:/				
	At the dorm, the number of current: Staff preser		Detaine	ACC.	
	The the dorm, the humber of eutrem. Start presen	it cens	Detame		
y]	mptoms_				
	Use no touch thermometer to record current ten				
	Since we last visited you, have you experienced		Onset Date		1
		Symptom Present Since Last Visit?	(mm/dd)	# of Days	Ongoing's
	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	☐Yes ☐No ☐Unk	/		
	Loss of smell Complete Partial	☐Yes ☐No ☐Unk	/		
	Zoos or smen Gomprete Grantum				



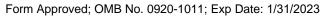


SARS-CoV-2 Louisiana Questionnaire V1 rev 5/20/2020

(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)	1
CDC ID	

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SARS-CoV-2 Louisiana Questionnaire V1 rev 5/20/2020

	-			CDC 1	ID:
dministrative Information Interviewer Name: First:	Last		Date	/ /	
Housing location: Dorm:Other:			Date	/ /	
Sleeping location: top bunk bottom bun					
Interviewee: Detainee					
interviewee Betainee					
mptoms					
Use no touch thermometer to record current te	mperature:	_°F			
Since we last tested you, have you experienced	any of the followin	g symptoms	?		
			Onset		
	Symptom Pro		Date	# of Days	Ongoing?
	Weel	ks?	(mm/dd)	•	0 0
Fever >100.4°F (38° C)	Yes No	Unk	/		
Subjective fever (felt feverish, or hot/sweaty)	☐Yes ☐No		/		
Chills	☐Yes ☐No				
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		/		
Abdominal pain	Yes No		/		
Diarrhea (≥3 loose stools/24hr period)	Yes No		/		
Nausea	Yes No		/		
Vomiting	Yes No		/		
Headache	Yes No		/		_
Loss of taste Complete Partial	Yes No		/		\vdash
Loss of smell Complete Partial	Yes No		/		
Other, specify:	Yes No	Unk	/		
ovement and Activity History Since we last tested you, have you?					
ctivity	Answer		Fr	equency	
. traveled outside your dorm?	Yes No	☐ Daily ☐		s a week 🗌 C	nce a week
•					
traveled outside the facility?	Yes No] A few time	s a week 🗌 C	ince a week
.gone to court? (Excludes video court)	☐ Yes ☐ No	Daily [A few time	s a week 🗌 C	nce a week
. had a work assignment off your dorm?	☐ Yes ☐ No	Daily [A few time	s a week 🗌 C	nce a week
. gone anywhere else?	☐ Yes ☐ No	If so, where	e:		
stantial Evnasura					
otential Exposure Since we last tested you, have you been around	l any people who an	near to be sig	ck with CO	VID-19 svmr	otoms such
a fever, cough, or shortness of breath?	any people who ap	pour to be si	,,,,,,,	, 17 17 19 111 ₁	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Yes No Unknown (If yes, how	many?)		

Form Approved OMB No. 0920-1011 Exp. Date 01/31/2023

COVID-19 Test Request Form

Public reporting burden of this collection of information is estimated to average 5 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)

COVID-19 Test Request Form

Do you have a PUI Number for this request? O Yes
O 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? *					
O Yes					
O No					
Influenza? *					
O Not Done					
O Negative					
O Positive					
O Pending					
Respiratory Virus Panel? *					
O Not Done					
O Negative					
O Positive					
O Pending					
Blood Cultures? *					
O Not Done					
O Negative					
O Positive					
O Pending					
Other Tests? *					
O Not Done					
O Negative					

	O Positive
	O Pending
-Doe	es the patient have any comorbid conditions? *
0	Yes
0	No

Step 1 of 5

