

**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)

**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	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units different time <input type="checkbox"/> Multiple units same time
Recreation Area (inside common area)	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units different time <input type="checkbox"/> Multiple units same time
Recreation Area or yard (outside)	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units different time <input type="checkbox"/> Multiple units same time
Commissary	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units different time <input type="checkbox"/> Multiple units same time
Other: _____	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units different time <input type="checkbox"/> Multiple units same time



# SARS-CoV-2 Correctional Facility Assessment

## V7 rev 5/11/2020

### (Correctional Facility Transmission Investigation)

#### 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.)
<input type="checkbox"/> Between each group	
<input type="checkbox"/> Multiple times a day, but not between each group	
<input type="checkbox"/> Once a day	
<input type="checkbox"/> 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**: \_\_\_\_\_



### SARS-CoV-2 Correctional Facility Assessment

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(Correctional Facility Transmission Investigation)

#### 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Muscle aches (myalgia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Runny nose (rhinorrhea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Stuffy nose (nasal congestion)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Shortness of breath (dyspnea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea (≥3 loose stools/24hr period)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Loss of taste <input type="checkbox"/> Complete <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell <input type="checkbox"/> Complete <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>

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)



**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):

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



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



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



**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.

### 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  Male  
 Non-Hispanic  Female

SEX

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

55836





## 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	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units different time <input type="checkbox"/> Multiple units same time
Showers	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units different time <input type="checkbox"/> Multiple units same time
Dining Area	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units different time <input type="checkbox"/> Multiple units same time
Recreation Area (inside common area)	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units different time <input type="checkbox"/> Multiple units same time
Recreation Area or yard (outside)	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units different time <input type="checkbox"/> Multiple units same time
Phone Access	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units different time <input type="checkbox"/> Multiple units same time
Computer Access	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units different time <input type="checkbox"/> Multiple units same time
Commissary	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units different time <input type="checkbox"/> Multiple units same time
Library	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units different time <input type="checkbox"/> Multiple units same time
Facility Healthcare Clinic	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted <input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units different time <input type="checkbox"/> Multiple units same time



### SARS-CoV-2 Correctional Facility Assessment

#### V3 rev 5/06/2020

(Correctional Facility Transmission Investigation)

Other: _____	<input type="checkbox"/> All the time <input type="checkbox"/> Restricted	<input type="checkbox"/> Cell only <input type="checkbox"/> Unit only <input type="checkbox"/> Multiple units
	<input type="checkbox"/> None <input type="checkbox"/> Unknown	different time <input type="checkbox"/> 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)



**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.**



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

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

**Administrative Information**

- Interviewer Name: First: \_\_\_\_\_ Last: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Housing location: Dorm: \_\_\_\_\_ Other: \_\_\_\_\_
- Sleeping location:   top bunk   bottom bunk
- Date quarantine initiated in dorm: \_\_\_\_/\_\_\_\_/\_\_\_\_
- At the dorm, the number of current: Staff present: \_\_\_\_\_ Cells: \_\_\_\_\_ Detainees: \_\_\_\_\_

**Demographic Information**

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

**Symptoms**

- Use no-touch thermometer to record current temperature: \_\_\_\_\_ °F
- 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Muscle aches (myalgia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Runny nose (rhinorrhea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Stuffy nose (nasal congestion)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Shortness of breath (dyspnea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea (≥3 loose stools/24hr period)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Loss of taste <input type="checkbox"/> Complete <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell <input type="checkbox"/> Complete <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>
Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>	<input type="checkbox"/>

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.*

- 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
- [If any use] When was the last time you used tobacco? \_\_\_\_\_ (MM/YYYY)
- 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
- [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**  
 (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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk/DK/Ref	<input type="checkbox"/> Asthma <input type="checkbox"/> COPD (chronic obstructive pulmonary disease) <input type="checkbox"/> Emphysema <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other, specify: _____
Diabetes or problems with your blood sugar?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk/DK/Ref	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 Are you taking insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart problems or high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk/DK/Ref	<input type="checkbox"/> Congenital heart abnormalities <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> Heart failure <input type="checkbox"/> High cholesterol (Hyperlipidemia) <input type="checkbox"/> High blood pressure (Hypertension) <input type="checkbox"/> Heart attack (Myocardial infarction) <input type="checkbox"/> Other, specify: _____
Kidney problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk/DK/Ref	<input type="checkbox"/> Chronic kidney disease <input type="checkbox"/> Dialysis <input type="checkbox"/> End-stage renal disease <input type="checkbox"/> Other, specify: _____
Liver problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk/DK/Ref	<input type="checkbox"/> Cirrhosis <input type="checkbox"/> End-stage liver disease <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Other, specify: _____
A disease, medication, or condition that weakens your immune system?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk/DK/Ref	<input type="checkbox"/> Chemotherapy <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Lupus <input type="checkbox"/> Steroids <input type="checkbox"/> Other, specify: _____
Learning or memory problems, stroke, seizure disorder, or history of head injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk/DK/Ref	<input type="checkbox"/> Dementia/Alzheimer's <input type="checkbox"/> Neurodevelopmental Disorder <input type="checkbox"/> Stroke <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Other, specify: _____
Do you have other health/medical problems you would like me to know about?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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





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

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

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**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?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
...traveled outside the facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
...gone to court? (Excludes video court)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
...had a work assignment off your dorm?	<input type="checkbox"/> Yes <input type="checkbox"/> No		



**SARS-CoV-2 Louisiana Questionnaire V3 rev 05/04/2020**  
(Correctional Facility Transmission Investigation)  
**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)	<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"/>
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>
Loss of taste <input type="checkbox"/> Complete <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>
Loss of smell <input type="checkbox"/> Complete <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>
Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___		<input type="checkbox"/>

**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? \_\_\_\_\_)



**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 \_\_\_\_\_

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



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

**Movement and Activity History**

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

Activity	Answer	Frequency
... traveled outside your dorm?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> A few times a week <input type="checkbox"/> Once a week
... traveled outside the facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> A few times a week <input type="checkbox"/> Once a week
... gone to court? (Excludes video court)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> A few times a week <input type="checkbox"/> Once a week
... had a work assignment off your dorm?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> A few times a week <input type="checkbox"/> Once a week
... gone anywhere else?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? \_\_\_\_\_)

## 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?

- 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 >