

<b>Interview Date:</b>
<b>Interviewer's Initials:</b>
<b>Household ID #:</b>

**Lyme and Other Tickborne Diseases Prevention Study  
Knowledge, Attitudes, and Practices  
Final Survey**

*This survey will be administered by phone to the person who signed the study consent form. If the head of household reports that a child was told by his/her doctor to have a tickborne disease, we will ask the head of household if he/she would be willing to answer questions on behalf of his/her child (while consulting the child). If the head of household reports that an adult household member (other than himself/herself) was told by his/her doctor to have a tickborne disease, we will ask the head of household if he/she would be willing to answer questions on behalf of this household member.*

Hello, my name is *(insert name)*. I'm calling on behalf of the *(insert site specific EIP title)* regarding a Lyme disease study that is being conducted in conjunction with the Centers for Disease Control and Prevention. *(insert head of household name)* has enrolled in this research study, and as part of this study, we would like to ask him/her to participate in a brief final study survey.

May I please speak with *(insert head of household name)*?

- Yes, speaking.** *(Go to dialog below)*
- Yes, let me get (contact name) on the phone.** *(Repeat introduction dialog above then go to dialog below)*
- Yes, but (contact name) is not home now/busy.**  
When would be a better time to reach him/her?  
*(Log date/time on call record.)* Thank you for your time today.
- No**  
Thank you for your time today.

If we have your permission, we would like to ask you some questions over the phone as the final survey for this study. This survey should take no more than 10 minutes to complete. As compensation for your time and effort, you will receive a gift card at the end of the study.

Would you like to participate in the final survey?

- Yes**  
Great, I will now begin to ask you the survey questions. *(Go to survey questions below)*
- Yes, but now is not a good time.**  
When would be a better time to speak?  
*(Log date/time on call record.)* Thank you for your time and interest in this study.
- No**

This study will help public health officials and scientists to better understand how to prevent Lyme disease and other tickborne diseases. Your participation would be a valuable contribution to this study. Would you reconsider?

**Yes**

Great, I will now begin to ask you the survey questions. *(Go to survey questions below)*

**No**

Thank you for your time today.

### Survey Questions

1. I would like to know if you spent a lot of time on vacation or at another home during the summer. During the study period (May-October), how much time did you spend at home?
  - 0 - 25% of the time
  - 26 - 50% of the time
  - 51 - 75% of the time
  - More than 75% of the time
  - Don't know
  - Refuse
  
2. I would like to know if your household members spent a lot of time on vacation or at another home during the summer. During the study period (May-October), how much time did your household members spend at home?
  - a. Member 1 (Enter Initials and Birth Year):
    - 0 - 25% of the time
    - 26 - 50% of the time
    - 51 - 75% of the time
    - More than 75% of the time
    - Don't know
    - Refuse
  - b. Member 2 (Enter Initials and Birth Year):
    - 0 - 25% of the time
    - 26 - 50% of the time
    - 51 - 75% of the time
    - More than 75% of the time
    - Don't know
    - Refuse
  - c. Member 3 (Enter Initials):
    - 0 - 25% of the time
    - 26 - 50% of the time

- 51 - 75% of the time
  - More than 75% of the time
  - Don't know
  - Refuse
- d. Etc....
3. Since enrolling in the study, did anyone living in your household (including yourself) find ticks attached to their body?
- Yes
    - a. Did you or this household member receive antibiotics for the tick bite(s) to avoid becoming sick?
      - Yes
        - i. Which antibiotic did you take? (*check all that apply*)
          - Doxycycline [dok-see-**sa**hy-kleen]
          - Amoxicillin [uh-mok-suh-**sil**-in]
          - Cefuroxime [**seff**-yur-**ox**-eem]
          - Ceftriaxone [**sef**-trye-**ax**-one]
          - Atovaquone [a-**toe**-va-kwone]
        - No
        - Don't know
        - Refuse
      - No
      - Don't know
      - Refuse
4. Since enrolling in the study, have you been told by a doctor or other healthcare worker that you had a tickborne disease (e.g., Lyme disease, anaplasmosis, or babesiosis)?
- Yes
  - No (*Go to question 11*)
  - Don't know (*Go to question 11*)
  - Refuse (*Go to question 11*)
5. Which tickborne disease did the doctor or other healthcare worker say you had? (check all that apply)
- Lyme disease
  - Anaplasmosis
  - Babesiosis
  - Ehrlichiosis
  - Other (please specify) \_\_\_\_\_
  - Don't know
  - Refuse

6. On what day did you start to feel sick or have symptoms:  
Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_  
 Don't know  
 Refuse
7. On what day did the doctor or other healthcare worker say that you had a tickborne disease?  
Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_  
 Don't know  
 Refuse
8. We would like to know how you were feeling when you were sick. Did you have any of the following symptoms? (*check all that apply*)
- Abdominal pain
  - Anemia
  - Anorexia- Loss of appetite
  - Body aches
  - Chills
  - Cough
  - Diarrhea
  - Expanding circular rash (sometimes called a Bull's Eye rash or EM rash)
  - Fatigue
  - Fever
  - Headache
  - Muscle pain
  - Nausea/vomiting
  - Joint pain
  - Severe headache (does not get better with pain medicine)
  - Sore throat
  - Stiff neck
  - Sweats
  - Swollen lymph nodes
  - Other (please specify) \_\_\_\_\_
  - Don't know
  - Refuse
9. Has your doctor given you medicine for your tickborne disease(s)?  
 Yes

- a. What medicine did your doctor give you to help you feel better? (*check all that apply*)
- Doxycycline [dok-see-**sa**hy-kleen]
  - Amoxicillin [uh-mok-suh-**sil**-in]
  - Cefuroxime [**seff**-yur-**ox**-eem]
  - Ceftriaxone [**sef**-trye-**ax**-one]
  - Atovaquone [a-**toe**-va-kwone]
  - Azithromycin [ay-**zith**-roe-**mye**-sin]
  - Clindamycin [**klin**-da-**mye**-sin]
  - Quinine [**kwye**-nine]
  - Other (please specify) \_\_\_\_\_
- No
  - Don't know
  - Refuse

10. We would like to know more about your tickborne disease(s). We would like to talk to your doctor about your symptoms and tests the doctor did when you were sick. If tests were done, we would like to request the test results. We will not ask your doctor anything else.

If this is okay, we will mail you a consent form and HIPAA authorization form and ask you to read and sign the forms. It is your choice if you would like to sign these forms which will allow us to access your health information/medical records on your tickborne disease(s).

Is it okay for us to mail you these forms?

- Yes
- No
- Don't know

It is okay that you would like more time to decide if you would like to receive these forms. Please call or email us if you decide to request these forms.

11. Since enrolling in the study, was someone in your household (other than you) told by a doctor or other healthcare worker that they had a tickborne disease?

- Yes

a. How many people living in your home were told they had a tickborne disease? \_\_\_\_\_

i. How many of these household members are minors (less than 18 years of age)?

\_\_\_\_\_

ii. How many of these household members are adults?

\_\_\_\_\_

- b. Is this person an adult or a child (less than 18 years of age)?
- CHILD**
- i. Would you be willing to consult this child and answer questions on his/her behalf about symptoms and treatment?
- Yes
- No
- ADULT**
- c. Would you be willing to answer questions on his/her behalf about symptoms and treatment?
- Yes
- No

- No
- Don't know
- Refuse

12. Which tickborne disease did the doctor or other healthcare worker say your child had?

*(check all that apply)*

- Lyme disease
- Anaplasmosis
- Babesiosis
- Ehrlichiosis
- Other (please specify) \_\_\_\_\_
- Don't know
- Refuse

13. On what day did your child start to feel sick or have symptoms:

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

- Don't know
- Refuse

14. On what day did the doctor or other healthcare worker say that your child had a tickborne disease?

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

- Don't know
- Refuse

15. We would like to know how your child was feeling when he/she was sick. Did your child have any of the following symptoms? *(check all that apply)*

- Abdominal pain
- Anemia
- Anorexia- Loss of appetite
- Body aches

- Chills
- Cough
- Diarrhea
- Expanding circular rash (sometimes called a Bull's Eye rash or EM rash)
- Fatigue
- Fever
- Headache
- Muscle pain
- Nausea/vomiting
- Joint pain
- Severe headache (does not get better with pain medicine)
- Sore throat
- Stiff neck
- Sweats
- Swollen lymph nodes
- Other (please specify) \_\_\_\_\_
- Don't know
- Refuse

16. Has your doctor given your child medicine for his/her tickborne disease(s)?

- Yes
  - a. What medicine did your doctor give you to help you feel better?  
(check all that apply)
    - Doxycycline [dok-see-**sahy**-kleen]
    - Amoxicillin [uh-mok-suh-**sil**-in]
    - Cefuroxime [**seff**-yur-**ox**-eem]
    - Ceftriaxone [**sef**-trye-**ax**-one]
    - Atovaquone [a-**toe**-va-kwone]
    - Azithromycin [ay-**zith**-roe-**mye**-sin]
    - Clindamycin [**klin**-da-**mye**-sin]
    - Quinine [**kwye**-nine]
    - Other (please specify) \_\_\_\_\_
- No
- Don't know
- Refuse

17. We would like to know more about your child's tickborne disease(s). We would like to talk to your child's doctor about his/her symptoms and tests the doctor did when he/she was sick. If tests were done, we would like to request the test results. We will not ask the doctor anything else.

If this is okay, we will mail you and your child a consent form and HIPAA authorization form and ask you and your child to read and sign the forms. It is your (and your child's) choice if you would like to sign these forms which will allow us to access your child's health information/medical records on his/her tickborne disease(s).

Is it okay for us to mail you these forms?

- Yes
- No
- Don't know

It is okay that you would like more time to decide if you would like to receive these forms. Please call or email us if you decide to request these forms.

18. Which tickborne disease did the doctor or other healthcare worker say this person had?  
(check all that apply)

- Lyme disease
- Anaplasmosis
- Babesiosis
- Ehrlichiosis
- Other (please specify) \_\_\_\_\_
- Don't know
- Refuse

19. On what day did this person start to feel sick or have symptoms:

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

- Don't know
- Refuse

20. On what day did the doctor or other healthcare worker say that this person had a tickborne disease?

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

- Don't know
- Refuse

21. We would like to know how this person was feeling when he/she was sick. Did this person have any of the following symptoms? (check all that apply)

- Abdominal pain
- Anemia
- Anorexia
- Body aches
- Chills
- Cough
- Diarrhea



- Expanding circular rash (sometimes called a Bull's Eye rash or EM rash)
- Fatigue
- Fever
- Headache
- Loss of appetite
- Muscle pain
- Nausea/vomiting
- Joint pain
- Severe headache (does not get better with pain medicine)
- Sore throat
- Stiff neck
- Sweats
- Swollen lymph nodes
- Other (please specify) \_\_\_\_\_
- Don't know
- Refuse

22. Has the doctor given this person medicine for his/her tickborne disease(s)?

- Yes
  - a. What medicine did the doctor give this person to help him/her feel better? (*check all that apply*)
    - Doxycycline [dok-see-**sa**hy-kleen]
    - Amoxicillin [uh-mok-suh-**sil**-in]
    - Cefuroxime [**sef**-yur-**ox**-eem]
    - Ceftriaxone [**sef**-trye-**ax**-one]
    - Atovaquone [a-**toe**-va-kwone]
    - Azithromycin [ay-**zith**-roe-**mye**-sin]
    - Clindamycin [**klin**-da-**mye**-sin]
    - Quinine [**kwye**-nine]
    - Other (please specify) \_\_\_\_\_
- No
- Don't know
- Refuse

This concludes the final study survey. Do you have any questions about the study or tickborne diseases?

For future questions, please call or email your State Health Department/EIP at XXX-XXX-XXX / [email address] or Sarah Hook, study coordinator (CDC), at XXX-XXX-XXX / shook@cdc.gov. Thank you for your participation in this survey.

