Interviewer Name: _____ **ODRS ID:**_____ **Date:** _____ / _____ / _____

COVID-19 CASE INTERVIEW & CONTACT FORM

=Optional

Last Name: _____ First Name:_____

Demographics

Date of Birth: _____/_____/_____ Age: _____ Gender: Male ☐ Female ☐

Pregnant? YES ☐ NO ☐ If YES, due date: _____ **Deceased? YES ☐ NO ☐ If YES, death date:**_____

Country of birth: _____ Ethnicity: Hispanic ☐ Non-Hispanic ☐

Needs Interpreter: YES ☐ NO ☐ If YES, Language: Unknown Other Language: _____

Race (*choose all that apply*): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other _____

Contact Information *(Please verify the jurisdiction)*

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Primary Phone: _____ Secondary Phone: _____

E-mail: _____

If patient is a minor (<18 years old):

Guardian Name: _____ Guardian Relationship to Case: _____

Work

Occupation: _____ Employer: _____

Job Duties:_____ Days worked before and during symptoms: _____

Employer Address:_____ Phone: _____

Healthcare Worker: YES ☐ NO ☐ UNK ☐

Resides in Long Term Care Facility: YES ☐ NO ☐ UNK ☐ If YES, name of LTCF: _____

First Responder: YES ☐ NO ☐ UNK ☐

Resides in Group Home: YES ☐ NO ☐ UNK ☐

Incarcerated in Correctional or Detention Facility: YES ☐ NO ☐ UNK ☐

Symptoms ***No Symptoms*** ☐

Date of Symptom Onset: _____/_____/_____ Last Date Symptoms Present: _____/_____/_____

Describe Initial Symptoms: _____

Was the patient hospitalized at any point during this illness? YES ☐ NO ☐

If YES, Hospital Name: _____ City: _____ State: _____

Date of Admission: ___/____/____ Date of Discharge: ___/____/____

Method of Arrival: Personal Vehicle ☐ EMS ☐ Public Transportation ☐ Other: _____

Primary Care Provider Name: _____

Clinic Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Did the patient see the above provider for this illness? YES ☐ NO ☐

If YES, Date of 1st visit: ____/____/____ Arrival Time: _____ Departure Time: _____

Date of 2nd visit: ____/____/____ Arrival Time: _____ Departure Time: _____

Date of 3rd visit: ____/____/____ Arrival Time: _____ Departure Time: _____

Method of Arrival: Personal Vehicle ☐ EMS ☐ Public Transportation ☐ Other: _____

Did the patient see a different provider for this illness? (*Include ER and Urgent Care)* YES ☐ NO ☐

If YES, Provider/Location Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Date of Visit: ____/____/_____ Arrival Time: _____ Departure Time: _____

Method of Arrival: Personal Vehicle ☐ EMS ☐ Public Transportation ☐ Other: _____

Interviewer Name: _____ **ODRS ID:**_____ **Date:** _____ / _____ / _____

=Optional

Symptoms:

Fever > 100.4 (38.C)	YES ☐	NO ☐	UNK ☐	
Subjective Fever (felt feverish?)	YES ☐	NO ☐	UNK ☐	
Chills	YES ☐	NO ☐	UNK ☐	
Muscle aches	YES ☐	NO ☐	UNK ☐	
Runny nose	YES ☐	NO ☐	UNK ☐	
Sore throat	YES ☐	NO ☐	UNK ☐	
Cough	YES ☐	NO ☐	UNK ☐	
Shortness of breath	YES ☐	NO ☐	UNK ☐	
Nausea or vomiting	YES ☐	NO ☐	UNK ☐	
Headache	YES ☐	NO ☐	UNK ☐	
Abdominal pain	YES ☐	NO ☐	UNK ☐	
Diarrhea	YES ☐	NO ☐	UNK ☐	
New olfactory and taste disorder(s)	YES ☐	NO ☐	UNK ☐	
Difficulty breathing	YES ☐	NO ☐	UNK ☐	
Conjunctivitis	YES ☐	NO ☐	UNK ☐	
Other (specify) _____				***No Symptoms*** ☐

Pre-existing medical conditions?	YES ☐	NO ☐	UNK ☐	
Chronic Lung Disease (asthma/COPD)	YES ☐	NO ☐	UNK ☐	
Diabetes Mellitus	YES ☐	NO ☐	UNK ☐	
Cardiovascular Disease (heart)	YES ☐	NO ☐	UNK ☐	
Chronic Renal (kidney) disease	YES ☐	NO ☐	UNK ☐	
Chronic Liver disease	YES ☐	NO ☐	UNK ☐	
Immunocompromised Condition	YES ☐	NO ☐	UNK ☐	
Neurologic/neurodevelopmental	YES ☐	NO ☐	UNK ☐	If YES, specify:_____
Other Chronic diseases	YES ☐	NO ☐	UNK ☐	If YES, specify:_____
Current smoker?	YES ☐	NO ☐	UNK ☐	
Former smoker?	YES ☐	NO ☐	UNK ☐	

During the 14 days prior to symptom onset*, were you in contact with anyone with COVID-19? YES ☐ NO ☐ UNK ☐
If YES, please collect Name/DOB/Address of <u>each</u> Case, then lookup in ODRS. Record ODRS ID numbers below:

Name: _____ DOB: ____/ ___/ ____ ODRS ID#: _____
Street: _____ City: _____ ZIP: _____

Name: _____ DOB: ____/ ___/ ____ ODRS ID#: _____
Street: _____ City: _____ ZIP: _____

*or 14 days prior to date of positive specimen collection, if person has no symptoms

Child Care/School

Attends Child Care? YES ☐ NO ☐ Center Name:_____ Classroom: _____
Last day and time attended: __/__/____ __:__ AM☐ PM☐ to __:__ AM☐ PM☐
Street Address: _____
City: _____ State: _____ Zip Code: _____ Phone: _____

Attends School? YES ☐ NO ☐ School Name:_____ Grade/Level:_____
Last day and time attended: __/__/____ __:__ AM☐ PM☐ to __:__ AM☐ PM☐
Street Address:_____
City: _____ State: _____ Zip Code: _____

Interviewer Name: _____ **ODRS ID:**_____ **Date:** _____ / _____ / _____

=Optional

Travel

Has case traveled outside Franklin County? YES ☐ NO ☐ UNK ☐ Date:___/___/____ to ___/___/____

Location to:_____Activities:_____Car/Air/Train/Bus/Boat/Other_____

Has case had visitors from outside Franklin County? YES ☐ NO ☐ UNK ☐ Date:___/___/____ to ___/___/____

Location:_____ Were they ill? YES ☐ NO ☐ UNK ☐ Type of Illness_____

Did the case travel on a cruise? YES ☐ NO ☐ UNK ☐

If YES, specify name, location, date of each event

_____

_____

_____

Did the case attend a concert, conference or other large events? YES ☐ NO ☐ UNK ☐

If YES, specify name, location, date of each event

_____

_____

_____

Did the case visit any healthcare settings? YES ☐ NO ☐ UNK ☐

If YES, specify name, location, date of each healthcare setting visited

_____

_____

_____

Public Transportation Details

If case activity **after symptom onset** included use of public transportation:

Destination #1: _____ Arrival Date: ___/____/____ Arrival Time: _____

Departure Date: ___/____/____ Departure Time: _____

Method of Travel: Taxi ☐ Airplane ☐ Train ☐ Bus ☐ Boat/Ferry ☐ Other:_____

Notes (*provide all travel details*):

_____

_____

Destination #2: _____ Arrival Date: ___/____/____ Arrival Time: _____

Departure Date: ___/____/____ Departure Time: _____

Method of Travel: Taxi ☐ Airplane ☐ Train ☐ Bus ☐ Boat/Ferry ☐ Other:_____

Notes (*provide all travel details*):

_____

_____

Destination #3: _____ Arrival Date: ___/____/____ Arrival Time: _____

Departure Date: ___/____/____ Departure Time: _____

Method of Travel: Taxi ☐ Airplane ☐ Train ☐ Bus ☐ Boat/Ferry ☐ Other:_____

Notes (*provide all travel details*):

_____

_____

Interviewer Name: _____ **ODRS ID:**_____ **Date:** _____ / _____ / _____

Mini Summary: *(Include last date of symptoms present)*

Isolation

Type of residence: House ☐ Apartment ☐ Other ☐ Specify: _____

Ability to stay in own bedroom? YES ☐ NO ☐ UNK ☐

Own bathroom? YES ☐ NO ☐ UNK ☐

At the time of interview, is the case isolated from household members? YES ☐ NO ☐ UNK ☐

Case information management

Patient interviewed: YES ☐ NO ☐

Medical record review: YES ☐ NO ☐

Case assigned to facilities group: YES ☐ NO ☐

Address:

Interviewer Name: _____ **ODRS ID:**_____ **Date:** ___/___/___ City, State, ZIP:

CONTACTS -List all information for anyone who has had close contact (at least 15 min. of time within 6 feet regardless of mask use) with the case. The time period of interest is from 2 days before onset of symptoms (or specimen date, if case has no symptoms) and for the duration of the isolation period. If the case is currently in isolation but unable to properly isolate, the Last Date of Exposure is the most recent date of contact, which may be the interview date. *Future dates should not be indicated here.* If the contact is already in ODRS or if you add them, put that ID number below the contact's name.

Name and ODRS ID#	DOB (or age, if unknown)	Relationship to Case	Symptomatic? Tested for COVID-19?	Exposure First Date / Last Date	Phone Number	Email
1) **ID:**	___/___/____ Age:		**S?** Y ☐ N ☐ UNK ☐ **T?** Y ◯ N ◯ UNK ◯	____/____/2020 ____/____/2020 ***Preferred Language:*** English		
HH? ☐ **Street:**			**City:**		**State:**	**ZIP:**
2) **ID:**	___/___/____ Age:		**S?** Y ☐ N ☐ UNK ☐ **T?** Y ◯ N ◯ UNK ◯	____/____/2020 ____/____/2020 ***Preferred Language:*** English		
HH? ☐ **Street:**			**City:**		**State:**	**ZIP:**
3) **ID:**	___/___/____ Age:		**S?** Y ☐ N ☐ UNK ☐ **T?** Y ◯ N ◯ UNK ◯	____/____/2020 ____/____/2020 ***Preferred Language:*** English		
HH? ☐ **Street:**			**City:**		**State:**	**ZIP:**
4) **ID:**	___/___/____ Age:		**S?** Y ☐ N ☐ UNK ☐ **T?** Y ◯ N ◯ UNK ◯	____/____/2020 ____/____/2020 ***Preferred Language:*** English		
HH? ☐ **Street:**			**City:**		**State:**	**ZIP:**
5) **ID:**	___/___/____ Age:		**S?** Y ☐ N ☐ UNK ☐ **T?** Y ◯ N ◯ UNK ◯	____/____/2020 /2020 ***Preferred Language:*** English		
HH? ☐ **Street:**			**City:**		**State:**	**ZIP:**
6) **ID:**	___/___/____ Age:		**S?** Y ☐ N ☐ UNK ☐ **T?** Y ◯ N ◯ UNK ◯	____/____/2020 ____/____/2020 ***Preferred Language:*** English		
HH? ☐ **Street:**			**City:**		**State:**	**ZIP:**
7) **ID:**	___/___/____ Age:		**S?** Y ☐ N ☐ UNK ☐ **T?** Y ◯ N ◯ UNK ◯	____/____/2020 ____/____/2020 ***Preferred Language:*** English		
HH? ☐ **Street:**			**City:**		**State:**	**ZIP:**
8) **ID:**	___/___/____ Age:		**S?** Y ☐ N ☐ UNK ☐ **T?** Y ◯ N ◯ UNK ◯	____/____/2020 ____/____/2020 ***Preferred Language:*** English		
HH? ☐ **Street:**			**City:**		**State:**	**ZIP:**
9) **ID:**	___/___/____ Age:		**S?** Y ☐ N ☐ UNK ☐ **T?** Y ◯ N ◯ UNK ◯	____/____/2020 /2020 ***Preferred Language:*** English		
HH? ☐ **Street:**			**City:**		**State:**	**ZIP:**
10) **ID:**	___/___/____ Age:		**S?** Y ☐ N ☐ UNK ☐ **T?** Y ◯ N ◯ UNK ◯	____/____/2020 /2020 ***Preferred Language:*** English		
HH? ☐ **Street:**			**City:**		**State:**	**ZIP:**

Symptomatic? Check Y, if contact has at least one of these: Cough, Shortness of Breath or Difficulty Breathing, Fever over 100.4F, New Loss of Taste or Smell.
HH? Check the box if this is a Household Contact, *meaning this person lives at the same address as listed on Page 1.* You do not need to repeat the address here.

Interviewer Name: _____ **ODRS ID:**_____ **Date:** _____ / _____ / _____

Use this space to record information on additional contacts or necessary notes not included elsewhere: