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Exposure Assessment of Healthcare Personnel to a Confirmed COVID-19 Case in a Healthcare Setting

CONFIRMED CASE ID: _____

I. INTERVIEW INFORMATION

Healthcare personnel (HCP) name: Last: _____ First: _____

Date of interview: MM / DD / YYYY Start time: _____ Stop time: _____

Interviewer name Last: _____ First: _____ Affiliation: _____

Last: _____ First: _____ Affiliation: _____

Last: _____ First: _____ Affiliation: _____

Who is providing information for this form?
- ☐ HCP
- ☐ Other, specify person (Last, First): _____ Relationship to HCP: _____

Sex: ☐ Male / ☐ Female / ☐ Other / ☐ Unknown Date birth: MM / DD / YYYY

HCP status:
- ☐ Confirmed case
- ☐ Contact of confirmed case, developed symptoms
- ☐ Contact of confirmed case, never developed symptoms

If tested for SARS-CoV-2:
Date of first positive specimen collection:
MM / DD / YYYY
☐ Unknown

Exposure risk stratification:
☐ High / ☐ Medium / ☐ Low / ☐ Undetermined

Result:
☐ Positive / ☐ Negative / ☐ Undetermined

If you developed symptoms, what was the date of very first onset? MM / DD / YYYY

Provide details about the following symptoms:

☐ Felt feverish	If so, date of onset: MM / DD / YYYY	Date of resolution: MM / DD / YYYY
☐ Cough (dry)	If so, date of onset: MM / DD / YYYY	Date of resolution: MM / DD / YYYY
☐ Cough (productive)	If so, date of onset: MM / DD / YYYY	Date of resolution: MM / DD / YYYY
☐ Sore Throat	If so, date of onset: MM / DD / YYYY	Date of resolution: MM / DD / YYYY
☐ Shortness of breath	If so, date of onset: MM / DD / YYYY	Date of resolution: MM / DD / YYYY
☐ Chills	If so, date of onset: MM / DD / YYYY	Date of resolution: MM / DD / YYYY
☐ Headache	If so, date of onset: MM / DD / YYYY	Date of resolution: MM / DD / YYYY
☐ Muscle Aches	If so, date of onset: MM / DD / YYYY	Date of resolution: MM / DD / YYYY
☐ Vomiting	If so, date of onset: MM / DD / YYYY	Date of resolution: MM / DD / YYYY
☐ Abdominal Pain	If so, date of onset: MM / DD / YYYY	Date of resolution: MM / DD / YYYY
☐ Diarrhea	If so, date of onset: MM / DD / YYYY	Date of resolution: MM / DD / YYYY
☐ Other	If so, date of onset: MM / DD / YYYY	Date of resolution: MM / DD / YYYY

If so, specify:

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II. MEDICAL HISTORY

Do you have any of the following physician-diagnosed medical conditions?

Asthma Yes ☐ / No ☐ / Unknown ☐

Allergic rhinitis Yes ☐ / No ☐ / Unknown ☐ **If yes, specify**_____

COPD Yes ☐ / No ☐ / Unknown ☐

Other chronic lung disease Yes ☐ / No ☐ / Unknown ☐ **If yes, specify**_____

Heart condition Yes ☐ / No ☐ / Unknown ☐ **If yes, specify**_____

Diabetes mellitus Yes ☐ / No ☐ / Unknown ☐ **If yes, specify**_____

Chronic kidney disease Yes ☐ / No ☐ / Unknown ☐ **If yes, specify**_____

Hemodialysis Yes ☐ / No ☐ / Unknown ☐

Immunosuppressive condition Yes ☐ / No ☐ / Unknown ☐ **If yes, specify**_____

Autoimmune disease Yes ☐ / No ☐ / Unknown ☐ **If yes, specify**_____

Active cancer Yes ☐ / No ☐ / Unknown ☐ **If yes, specify**_____

Hypertension Yes ☐ / No ☐ / Unknown ☐ **If yes, specify**_____

Other medical condition(s) Yes ☐ / No ☐ / Unknown ☐

If yes, specify_____

Taking immune suppressant medications (corticosteroid, chemotherapy, other)? Yes ☐ / No ☐ / Unknown ☐

If yes, specify_____

Taking any other medications? Yes ☐ / No ☐ / Unknown ☐

If yes, specify_____

Pregnant Yes ☐ / No ☐ / Unknown ☐ / Not relevant (male) ☐

If yes, specify number of gestational weeks _____

Current smoker (includes tobacco, vaping, marijuana) Yes ☐ / No ☐ **If yes, how often?** _____

Former smoker (includes tobacco, vaping, marijuana) Yes ☐ / No ☐ **If yes, years since quitting:** _____

Height _____ feet/inches Weight _____ pounds

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III. GENERAL INFORMATION

Healthcare personnel role (check all that apply):

- ☐ Environmental services worker
- ☐ Facilities/maintenance worker
- ☐ Food services worker
- ☐ Laboratory worker
- ☐ Licensed practical nurse
- ☐ Medical technician
- ☐ Nurse practitioner
- ☐ Nursing assistant
- ☐ Nutritionist
- ☐ Occupational therapist
- ☐ Ward clerk
- ☐ Pharmacy worker
- ☐ Phlebotomist
- ☐ Physical therapist
- ☐ Physician assistant
- ☐ Physician (intern/resident)
- ☐ Physician (fellow)
- ☐ Physician (attending)
- ☐ Radiology technician
- ☐ Registered nurse
- ☐ Respiratory therapist
- ☐ Speech therapist
- ☐ Student
- ☐ Teacher/Preceptor
- ☐ Other (specify):

Principal work facility type:

- ☐ Hospital
- ☐ Outpatient clinic, specify clinic type _____
- ☐ Urgent care clinic/ED
- ☐ Nursing home or skilled nursing facility
- ☐ Dialysis unit/center
- ☐ Other, specify _____

In which area(s) of the facility did your exposure(s) to the COVID-19 patient occur? (check all that apply):

- ☐ Reception area
- ☐ Intensive care unit patient room
- ☐ Radiology/imaging
- ☐ Transport
- ☐ Operating room
- ☐ Other _____
- ☐ Emergency room examination room
- ☐ Inpatient ward room
- ☐ Laboratory
- ☐ Outpatient examination room
- ☐ Endoscopy room
- ☐ Unknown

Did you enter a room less than 2 hours after it had been vacated by the COVID-19 patient?

- ☐ Yes
- ☐ No
- ☐ Unknown
- ☐ Not applicable

If yes, did you enter before environmental cleaning was performed?

- ☐ Yes
- ☐ No
- ☐ Unknown

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Dates and times when caring for the COVID-19 patient during shifts (print additional pages as needed):

Facility Name	Date	Shift Time	Location (i.e., unit)	Role

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IV. PATIENT CARE ACTIVITIES AND EXPOSURES

Indicate specific exposures that you had with the confirmed or suspected COVID-19 patient(s) (check all that apply):

Patient care activities and procedures (excluding Aerosol-generating procedures):

- ☐ Taking vital signs
- ☐ Taking medical history
- ☐ Performing physical exam
- ☐ Providing medication
- ☐ Manipulation of oxygen face mask or tubing
- ☐ Insertion of peripheral line
- ☐ Insertion of nasogastric tubes
- ☐ Participating in surgery
- ☐ ABG
- ☐ Placing urinary catheter
- ☐ Bathing
- ☐ Feeding
- ☐ Lifting, positioning
- ☐ Manipulation of ventilator or tubing
- ☐ Insertion of central line
- ☐ Tracheostomy care
- ☐ Collecting respiratory specimens
- ☐ Chest tube (insert or remove)
- ☐ Emptying bedpan
- ☐ Changing linen
- ☐ Cleaning the room
- ☐ ECMO
  - ☐ Caring for ☐ Start ☐ Take off
- ☐ High flow oxygen delivery
  - ☐ Caring for ☐ Place nasal cannula ☐ Remove nasal cannula
- ☐ Other:
- ☐ Hemodialysis
- ☐ Drawing blood
- ☐ Providing injection
- ☐ Performing X-ray

What PPE were you wearing during the above patient care activities and procedures for the confirmed or suspected COVID-19 patient(s)?

Gloves	☐ All the time	☐ Sometimes	☐ Never
Gown	☐ All the time	☐ Sometimes	☐ Never
N95 respirator	☐ All the time	☐ Sometimes	☐ Never
PAPR	☐ All the time	☐ Sometimes	☐ Never
Facemask	☐ All the time	☐ Sometimes	☐ Never
Goggles or face shield	☐ All the time	☐ Sometimes	☐ Never

Any additional details to share about the above patient care activities and procedures for the confirmed or suspected COVID-19 patient(s)?

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Aerosol-generating procedures (AGP) during patient care activities for the confirmed or suspected COVID-19 patient(s):

☐ Airway suctioning	Gloves	☐ All the time	☐ Sometimes	☐ Never
	Gown	☐ All the time	☐ Sometimes	☐ Never
☐ Performed or assisted ☐ Present in room	N95 respirator	☐ All the time	☐ Sometimes	☐ Never
	PAPR	☐ All the time	☐ Sometimes	☐ Never
Number of procedures: _____	Facemask	☐ All the time	☐ Sometimes	☐ Never
Average length of procedure: _____	Goggles or face shield	☐ All the time	☐ Sometimes	☐ Never
☐ Non-invasive ventilation (e.g., BiPAP, CPAP)	Gloves	☐ All the time	☐ Sometimes	☐ Never
	Gown	☐ All the time	☐ Sometimes	☐ Never
☐ Performed or assisted ☐ Present in room	N95 respirator	☐ All the time	☐ Sometimes	☐ Never
	PAPR	☐ All the time	☐ Sometimes	☐ Never
Number of procedures: _____	Facemask	☐ All the time	☐ Sometimes	☐ Never
Average length of procedure: _____	Goggles or face shield	☐ All the time	☐ Sometimes	☐ Never
☐ Manual (bag) ventilation	Gloves	☐ All the time	☐ Sometimes	☐ Never
	Gown	☐ All the time	☐ Sometimes	☐ Never
☐ Performed or assisted ☐ Present in room	N95 respirator	☐ All the time	☐ Sometimes	☐ Never
	PAPR	☐ All the time	☐ Sometimes	☐ Never
Number of procedures: _____	Facemask	☐ All the time	☐ Sometimes	☐ Never
Average length of procedure: _____	Goggles or face shield	☐ All the time	☐ Sometimes	☐ Never
☐ Nebulizer treatments	Gloves	☐ All the time	☐ Sometimes	☐ Never
	Gown	☐ All the time	☐ Sometimes	☐ Never
☐ Performed or assisted ☐ Present in room	N95 respirator	☐ All the time	☐ Sometimes	☐ Never
	PAPR	☐ All the time	☐ Sometimes	☐ Never
Number of procedures: _____	Facemask	☐ All the time	☐ Sometimes	☐ Never
Average length of procedure: _____	Goggles or face shield	☐ All the time	☐ Sometimes	☐ Never

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☐ Intubation	Gloves	☐ All the time	☐ Sometimes	☐ Never
	Gown	☐ All the time	☐ Sometimes	☐ Never
☐ Performed or assisted ☐ Present in room	N95 respirator	☐ All the time	☐ Sometimes	☐ Never
	PAPR	☐ All the time	☐ Sometimes	☐ Never
Number of procedures: _____	Facemask	☐ All the time	☐ Sometimes	☐ Never
Average length of procedure: _____	Goggles or face shield	☐ All the time	☐ Sometimes	☐ Never
☐ Code / CPR	Gloves	☐ All the time	☐ Sometimes	☐ Never
	Gown	☐ All the time	☐ Sometimes	☐ Never
☐ Performed or assisted ☐ Present in room	N95 respirator	☐ All the time	☐ Sometimes	☐ Never
	PAPR	☐ All the time	☐ Sometimes	☐ Never
Number of procedures: _____	Facemask	☐ All the time	☐ Sometimes	☐ Never
Average length of procedure: _____	Goggles or face shield	☐ All the time	☐ Sometimes	☐ Never
☐ High-frequency oscillatory ventilation (HFOV)	Gloves	☐ All the time	☐ Sometimes	☐ Never
	Gown	☐ All the time	☐ Sometimes	☐ Never
☐ Performed or assisted ☐ Present in room	N95 respirator	☐ All the time	☐ Sometimes	☐ Never
	PAPR	☐ All the time	☐ Sometimes	☐ Never
Number of procedures: _____	Facemask	☐ All the time	☐ Sometimes	☐ Never
Average length of procedure: _____	Goggles or face shield	☐ All the time	☐ Sometimes	☐ Never
☐ Chest physiotherapy	Gloves	☐ All the time	☐ Sometimes	☐ Never
	Gown	☐ All the time	☐ Sometimes	☐ Never
☐ Performed or assisted ☐ Present in room	N95 respirator	☐ All the time	☐ Sometimes	☐ Never
	PAPR	☐ All the time	☐ Sometimes	☐ Never
Number of procedures: _____	Facemask	☐ All the time	☐ Sometimes	☐ Never
Average length of procedure: _____	Goggles or face shield	☐ All the time	☐ Sometimes	☐ Never

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☐ Mini BAL	Gloves	☐ All the time	☐ Sometimes	☐ Never
	Gown	☐ All the time	☐ Sometimes	☐ Never
☐ Performed or assisted ☐ Present in room	N95 respirator	☐ All the time	☐ Sometimes	☐ Never
	PAPR	☐ All the time	☐ Sometimes	☐ Never
Number of procedures: _____	Facemask	☐ All the time	☐ Sometimes	☐ Never
Average length of procedure: _____	Goggles or face shield	☐ All the time	☐ Sometimes	☐ Never
☐ Breaking ventilation circuit (intentionally or unintentionally)	Gloves	☐ All the time	☐ Sometimes	☐ Never
	Gown	☐ All the time	☐ Sometimes	☐ Never
☐ Performed or assisted ☐ Present in room	N95 respirator	☐ All the time	☐ Sometimes	☐ Never
	PAPR	☐ All the time	☐ Sometimes	☐ Never
Number of procedures: _____	Facemask	☐ All the time	☐ Sometimes	☐ Never
Average length of procedure: _____	Goggles or face shield	☐ All the time	☐ Sometimes	☐ Never
☐ Sputum induction	Gloves	☐ All the time	☐ Sometimes	☐ Never
	Gown	☐ All the time	☐ Sometimes	☐ Never
☐ Performed or assisted ☐ Present in room	N95 respirator	☐ All the time	☐ Sometimes	☐ Never
	PAPR	☐ All the time	☐ Sometimes	☐ Never
Number of procedures: _____	Facemask	☐ All the time	☐ Sometimes	☐ Never
Average length of procedure: _____	Goggles or face shield	☐ All the time	☐ Sometimes	☐ Never
☐ Bronchoscopy	Gloves	☐ All the time	☐ Sometimes	☐ Never
	Gown	☐ All the time	☐ Sometimes	☐ Never
☐ Performed or assisted ☐ Present in room	N95 respirator	☐ All the time	☐ Sometimes	☐ Never
	PAPR	☐ All the time	☐ Sometimes	☐ Never
Number of procedures: _____	Facemask	☐ All the time	☐ Sometimes	☐ Never
Average length of procedure: _____	Goggles or face shield	☐ All the time	☐ Sometimes	☐ Never

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What is the longest amount of time that you were in a room or other location with the confirmed or suspected COVID-19 patient(s)?

☐ <=2 minutes ☐ >2 and =<30 minutes ☐ >30 and =<60 minutes
☐ >60 minutes ☐ Unknown

What is the total amount of time that you were in a room or other location with the confirmed or suspected COVID-19 patient(s)?

Estimated: _____

How close did you get to the confirmed or suspected COVID-19 patient(s)?

☐ Within 6 feet or less ☐ More than 6 feet away

Did the confirmed or suspected COVID-19 patient(s) have source control (e.g., wear a mask, intubated) when contact occurred?

☐ All the time ☐ Sometimes ☐ Never
If source control was present, specify: _____

Was/were the confirmed or suspected COVID-19 patient(s) placed in an Airborne Infection Isolation Room (AIIR) when contact occurred?

☐ All the time ☐ Sometimes ☐ Never

Did you have any concerns with PPE (e.g., tears, needing change or replace PPE while in the room) or hand hygiene practices?

☐ Yes ☐ No If yes, describe: _____

Did you have any direct exposures to your mucous membranes/skin with the patient's respiratory secretions/other body fluids/blood?

☐ Yes ☐ No ☐ Unknown

Did you have any percutaneous exposures (i.e. needle sticks, cuts)?

☐ Yes ☐ No ☐ Unknown

Did you have any known direct skin-skin exposure to the confirmed or suspected COVID-19 patient(s)?

☐ Yes ☐ No ☐ Unknown

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V. ADDITIONAL NOTES AND QUESTIONS

Consider asking:
Did you have any additional questions for us?
Is there anything else notable you would like to mention?

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January 2020

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February 2020

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29

March 2020

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

April 2020

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

May 2020

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

June 2020

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

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