COVID-19 CONTACT NOTIFICATION / INFORMATION

This document is intended to guide the notification of close contacts of COVID-19 cases so that they may begin self-quarantine and symptom monitoring, as recommended.

WEDSS ID of the index case-patient	**WEDSS ID of the contact**

WEDSS Outbreak ID

Interviewer Information

Name of Interviewer completing this phone call	Date of Interview completed

State/Local Health Department (Name local health department)

Who is providing information to interviewer?

☐ Contact

☐ Other Specify person (Name - Last, First) _____

Relationship to contact _____

Pre-Interview - Information (Pre-fill information from WEDSS or COVID-19 Contact Tracing, F-02717A)

Contact Name – First, Middle Initial, Last

Contact's primary language	Will contact need to be interviewed via an Interpreter? ☐ Yes ☐ No

Age	Approximate year of birth	Sex ☐ Male ☐ Female

Date of last contact with case-patient? [WEDSS Tab 2019-nCoV Monitoring]	14-days after last contact date (quarantine end date) *Please enter this date into WEDSS*

Other locating information (if applicable)

WEDSS ID of the index case-patient	**WEDSS ID of the contact**

CONTACT'S INFORMATION (Person being notified of exposure)

Last Name First Name Middle Initial

Current Address City State Zip

Phone No. Personal email address

DEMOGRAPHIC INFORMATION

Date of birth mm/dd/yyyy)	Age	Sex	Gender:
	☐ years ☐ months	☐ Male ☐ Female	☐ Transgender: ☐ Male to Female ☐ Female to Male

If contact is female and of childbearing age (14-55), please ask:

Are you currently pregnant? ☐Yes ☐No ☐Unknown If yes, please enter the estimated delivery date _____

Do you consider yourself: **Ethnicity**

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Not Specified

With which of the following do you identify: **Race**

☐ White ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

☐ Asian ☐ Black or African American ☐ Other _____

☐ Unknown If **Unknown**, please specify ☐ Declined to answer ☐ Not Asked

OCCUPATION INFORMATION

Work/School – Name

Occupation (*Be specific: e.g. janitor, accountant, stock clerk, farmhand, practical nurse, chemist)* (return to page 6)

Industry*/Occupation Setting (Be specific: e.g. retail bakery, retail drug store, iron foundry, meat packing plant, physician's office, paper mill)*

Work/School Address (Include City, and Zip Code)

WEDSS ID of the index case-patient	**WEDSS ID of the contact**

Laboratory and Clinical Information [*WEDSS tab: 2019-nCoV LabClinic*]

Symptoms [*WEDSS Section: 2019-nCoV Signs and Symptoms*]

Which of the following symptoms have you experienced in the last 14 days? Please check all that apply.

Symptom	**Symptom Present?**
Fever (Temperature_____)	☐
Cough (new onset or worsening of chronic cough)	☐
Sore throat	☐
Shortness of breath (dyspnea)	☐
Nausea	☐
Abdominal pain	☐
Loss of smell	☐
Fatigue	☐
Chills	☐
Headache	☐
Muscle aches (myalgia)	☐
Runny nose (rhinorrhea)	☐
Vomiting	☐
Diarrhea (>3 loose stools/day)	☐
Loss of taste	☐
Other, specify _____	☐
None	☐

If any symptom was present, what date did your symptom(s) begin? ("This refers to the first day the patient began to feel sick, which could include new or worsening cough, sore throat, runny nose, fever, headache, or shortness of breath) **Date of symptom onset**:_____

At the time of the interview, had all of the symptoms of the contact resolved? ☐ Yes ☐ No
If **yes**, please note the date of resolution _____

Notes:

WEDSS ID of the index case-patient	**WEDSS ID of the contact**

Laboratory and Clinical information continued.

Medical Provider Information [WEDSS Section Medical Care Providers (2019-nCoV)]

Did you go to the doctor for any of the symptoms you experienced? ☐ Yes ☐ No ☐ Unknown

Note: This includes testing at a clinic or hospital. If patient received drive-thru or community testing, please skip this section and go to page 5.

What type of medical care was sought? ☐ Outpatient ☐ Inpatient

Clinic/hospital name

Medical Provider Name	Provider Phone

Date of clinic visit/hospital admission	Date of inpatient discharge

Admitted to the Intensive Care Unit (ICU)	☐ Yes ☐ No ☐ Unknown
Intubated	☐ Yes ☐ No ☐ Unknown
On ECMO (life-support)	☐ Yes ☐ No ☐ Unknown

Laboratory and Clinical Information Notes:

Do you have any of the following medical conditions? Check all that apply.

Medical Condition	**Condition(s) Present?**
No medical conditions	☐
Diabetes	☐
Hypertension (high blood pressure)	☐
Emphysema (COPD)	☐
Unknown disease	☐
Cardiac (heart) disease	☐
Asthma	☐
Chronic kidney disease	☐
Other chronic pulmonary disease Please specify _____	☐
Chronic liver disease	☐
Immunocompromised (*Any disease that puts you at higher risk of infection*)	☐
Neurological/neurodevelopmental disease Please specify _____	☐
Other, specify _____	☐

WEDSS ID of the index case-patient	**WEDSS ID of the contact**

Other laboratory/clinical questions

Is the contact a current or former smoker? ☐ Current ☐ Former ☐ Never smoked ☐ Unknown

Any upcoming medical appointments in the next 14 days? ☐ Yes ☐ No ☐ Unknown
If **yes**, please specify: _____

Notes:

COVID19 Risks [WEDSS Tab 2019-nCoV Risk]

RESIDENTIAL SETTING	Yes	No	Unknown
Are you currently living in stable housing that you own, rent, or stay in as part of a household?	☐	☐	☐
Where does the contact live?			
Single family home?	☐	☐	☐
Apartment/condo/duplex/townhome?	☐	☐	☐
If **Yes**; does it have a common entrance or shared spaces?	☐	☐	☐
How many other people live in the same home/apartment/condo?			
Do you have any pets or responsibilities for caring for animals?	☐	☐	☐
Group or congregate setting where multiple unrelated people reside (e.g. long-term care facility, jail, prison, dormitory; this may or may not be a licensed or inspected facility) If **Yes**, type of setting: _____ If Other, please specify name, address, and details of group residence:	☐	☐	☐

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OCCUPATION AND OCCUPATION SETTING

What is the contact's occupation? _____

Does this contact have multiple jobs? If so, please list name and location of the other jobs:

Occupation and Occupation Setting	Yes	No	Unknown
Is the contact a healthcare worker?	☐	☐	☐
Is the contact a member of law enforcement?	☐	☐	☐
Is the contact a first responder/emergency medical services provider?	☐	☐	☐
Does the contact work in a group or congregate setting? If **Yes**, select setting type: _____ If **Other**, please specify: _____ Name, address, and details for group residence:	☐	☐	☐
Does the contact volunteer? If so, please list organization and location of volunteer job.	☐	☐	☐
Does the contact work at or are they a child who attends a child care facility? Facility name, details, dates of attendance:	☐	☐	☐
Did the contact recently attend a gathering, party, or meeting with people from outside their household?	☐	☐	☐
If **yes**, were any of those people ill or did any become ill? Details: _____	☐	☐	☐

Symptom Self-Monitoring

Is the contact willing to self-monitor their symptoms? ☐ Yes ☐ No

If **Yes**, please provide their email address: _____

Indicate a **one** morning, **A.M**. AND **one** evening **P.M**. reporting time
If they do not indicate a time preference, please choose 12 p.m.

A.M. reporting time:			**P.M**. reporting time:		
☐ 5 a.m.	☐ 6 a.m.	☐ 7 a.m.	☐ 12 p. m.	☐ 1 p.m.	☐ 2 p.m.
☐ 8 a.m.	☐ 9 a.m.	☐ 10 a.m.	☐ 3 p.m.	☐ 4 p.m.	☐ 5 p.m.
☐ 11 a.m.			☐ 6 p.m.		

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ISOLATION AND QUARANTINE [WEDSS Tab 2019-nCoV Intervention]	Yes	No	Unsure
Is the contact quarantined?	☐	☐	☐
If **yes**, please note the start and end date of quarantine Quarantine start date:_____ Quarantine end date:_____			
Employer/School/Other notified of quarantine	☐	☐	☐
Were quarantine orders issued? *Note: this is only for LTHD use* Date quarantine order was issued: _____	☐	☐	☐
Is the contact quarantined at own residence? If No, address of location person is being quarantined	☐	☐	☐
Do you think you have concerns about your safety at home while you are in quarantine? ☐ Declined to answer	☐	☐	☐
Do you have needs related to any of the following resources while you are in quarantine? *If they say yes to any of the following, please refer them to 2-1-1 resources.*			
Food	☐	☐	☐
Personal care items/Medications	☐	☐	☐
Bills	☐	☐	☐
Cleaning supplies	☐	☐	☐
Other needs – please specify: _____	☐	☐	☐

Additional information:

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Health Teaching provided to contact (Please select all that apply)	
☐ Fact sheets offered	☐ Other, please specify: _____
☐ Information found on the internet	☐ Reviewed isolation/quarantine instructions

Notes: