CUYAHOGA COUNTY
BOARD OF HEALTH

Cluster Name: _____
CCBH Cluster ID#: _____

COVID-19 Interview v4

First Name: _____ **Last Name:** _____ **DOB:** _____ **Age:** _____

Gender: ☐ Male ☐ Female ☐ Nonbinary ☐ Unknown/declined

Preferred Language: ☐ English ☐ Other _____

Address: _____

City: _____ State: _____ Zip code: _____

Residing at this address? ☐ Yes ☐ No **If No, Alternate address is:** _____

Phone/email: _____ ☐H ☐C **Phone/email:** _____ ☐H ☐C

Other Informant Information:

Name: _____ **Relationship:** _____ **Alt. Phone/email:** _____

Isolation **ODRS#: _____**	**Quarantine**
☐ Lab-Confirmed Case Date of specimen collection: _____ ☐ Probable Case Related Case Name: _____ Related Case ODRS#: _____	Start Date _____ End Date _____ Extended to: _____ ☐ Asymptomatic ☐ Symptomatic - continue as a case (continue in isolation column of this form)
Date of symptom onset: _____ ☐ Asymptomatic ☐ Unknown Symptom Resolution Date _____ Clearance ☐ Y ☐ N ☐ Unk D/C Date _____ Death ☐ Y ☐ N ☐ Unk Date _____	Last Date of Exposure: _____ Related Case Name: _____ Related Case ODRS#: _____ Other exposure: _____
☐ Date of interview _____ Name of interviewer: _____ ☐ Isolation Packet Sent ☐ Emailed Date sent: _____ Initials: _____ ☐ D/C Isolation ☐ Emailed Date sent: _____ Initials: _____	Date of interview: _____ Name of Interviewer: _____ Quarantine Packet Sent - ☐ Y ☐ N ☐ Unk ☐ Emailed Date sent: _____ Initials: _____

Unsuccessful contact attempt(s):

Attempt 1 Date: _____

Attempt 2 Date: _____

Attempt 3 Date:

Notes:

Race (check all that apply):
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Unknown ☐ Other, specify: _____

Ethnicity:
☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown

Pregnant:
☐ No ☐ Unknown
☐ Yes Delivery Hospital _____ Due Date: _____ Plan to Breastfeed: ☐Y☐N☐Unk
Gestation week at diagnosis: _____

Institutionalized:
☐ No ☐ Unknown
☐ Yes **Facility Name:**
Facility Type: ☐ Assisted Living ☐ Nursing Home ☐ Skilled Nursing Facility ☐ Group Home
☐ Correctional ☐ Shelter ☐ Other (specify): _____

Employed/Working:
☐ No ☐ Retired ☐ Unknown
☐ Yes Employment Setting: _____
Date Last Worked: _____ Facility Notified? ☐Y ☐N ☐NA
Essential Worker? ☐Y ☐N ☐Unk Able to telework? ☐Y ☐N ☐Unk Has sick leave available? ☐ Y☐N ☐Unk
Health Care Worker? ☐Y ☐N
Facility Name: _____ Type of HCW: _____
Type of PPE worn: _____ (any breaches in PPE specify in contacts in contact section)
Date Last Worked: Facility Notified? ☐Y ☐N ☐NA
Works at multiple places? ☐Y ☐N
List all facilities case has worked at: _____

Housing:
Separate Room? ☐Y ☐N ☐Unk Separate Bathroom? ☐Y ☐N ☐Unk
Household Size (total number including interviewee): _____
Caregiver for vulnerable: ☐Y ☐N ☐Unk Specify: _____

Primary Care Provider or Usual Source of Care:
☐ No
☐ Yes Specify: _____

Resource Needs:
Are there barriers to reducing the risk to those who live in the household and for complete isolation or quarantine?
☐No ☐ Yes
Check the needs identified and specify requests.
☐ Access to food or essential goods (e.g. medicine) ☐ Cleaning Supplies ☐ PPE ☐ Internet
☐ Job Security/Requirement ☐ Stable Housing ☐ Thermometer
Specify: _____
Date resource need was given to resource team (Inform PHN Supervisor): _____