Health Care Worker Surveillance Case Investigation Form

Contact Identifier Information			
First name:		Surname:	
Sex	□ Male □ Female □ Not known	Date of Birth (DD/MM/YYYY) _____/__/__	
Age (years, months)			
Email		Telephone number:	
Address:			
Parish:			
Smoker		□ Yes □ No	
Occupation in health care facility □ Medical doctor □ Registered nurse (or equivalent) □ Assistant nurse, nurse technician (or equivalent) □ Radiology / x-ray technician □ Phlebotomists □ Physical therapists		□ Nutritionists/dietitians □ Other health care provider: □ Lab personnel □ Admission/reception clerks □ Patient transporters □ Catering staff □ Cleaners	
Infection prevention and control measures information			
What date was your most recent IPC training within the health care facility? (DD/MM/YYYY)		DD/MM/YYYY	
How much cumulative IPC training (standard precautions, additional precautions) have you had at this health care facility?		□ Less than 2 hours □ More than 2 hours	
Do you follow recommended hand hygiene practices? □ Always, as recommended □ Most of the time □ Occasionally □ Rarely			
Do you use alcohol-based hand rub or soap and water before touching a patient? □ Always, as recommended □ Most of the time □ Occasionally □ Rarely			
Do you use alcohol-based hand rub or soap and water before cleaning/aseptic procedures? □ Always, as recommended □ Most of the time □ Occasionally □ Rarely			
Do you use alcohol-based hand rub or soap and water after (risk of) body fluid exposure? □ Always, as recommended □ Most of the time □ Occasionally □ Rarely			
Do you use alcohol-based hand rub or soap and water after touching a patient? □ Always, as recommended □ Most of the time □ Occasionally □ Rarely			
Do you use alcohol-based hand rub or soap and water after touching a patient's surroundings? □ Always, as recommended □ Most of the time □ Occasionally □ Rarely			
Do you follow IPC standard precautions when in contact with any patient? □ Always, as recommended □ Most of the time □ Occasionally □ Rarely □ I don't know what IPC standard precautions are			
Do you wear PPE when indicated? (PPE includes: Medical mask, Face shield, Gloves, Goggles/glasses, Gown, Coverall, Head cover, Respirator (e.g. N95 or equivalent), Shoe covers)		□ Always, according to the risk assessment □ Most of the time, according to the risk assessment □ Occasionally □ Rarely	
Is PPE available in sufficient quantity in the health care facility?		□ Yes □ No □ Unknown	
Exposures to COVID-19 infected patient			
Date of admission of 2019-nCoV confirmed patient (DD/MM/YYYY)		DD/MM/YYYY:	

MINISTRY OF HEALTH & WELLNESS

Have you had close contact (within 1 meter) with the patient since his/her admission?
□ Yes □ No □ Unknown

- If yes, how many times (total)?

- If yes, for how long each time? □ <5 minutes □ 5-15 minutes □ >15 minutes

- If yes, did you have prolonged face-to-face exposure (>15 minutes)? □ Yes □ No □ Unknown

If yes, did you wear PPE? □ Yes □ No □ Unknown

If yes, what type? Tick all that apply:

□ Medical mask □ Face shield □ Gloves □ Goggles/glasses □ Gown
□ Coverall □ Head cover □ Respirator (e.g. N95 or equivalent) □ Shoe covers

- If you were wearing a medical mask, what type:

- If you were wearing a respirator, was it test fitted? □ Yes □ No □ Unknown

- If you were wearing gloves, did you remove gloves after contact with the patient? □ Yes □ No

- If yes, did you perform hand hygiene before contact with the patient?

□ Always, as recommended □ Most of the time □ Occasionally □ Rarely

If yes:

□ Alcohol-based hand rub □ Soap and water □ Water

- If yes, did you perform hand hygiene after contact with the patient?

□ Always, as recommended □ Most of the time □ Occasionally □ Rarely

If yes:

□ Alcohol-based hand rub □ Soap and water □ Water

- If yes, were you present for any aerosolising procedures performed on the patient? □ Yes □ No □ Unknown

If yes, describe the procedure:

If yes, did you wear PPE? □ Yes □ No □ Unknown

If yes, what type? Tick all that apply:

□ Medical mask □ Face shield □ Gloves □ Goggles/glasses □ Gown
□ Coverall □ Head cover □ Respirator (e.g. N95 or equivalent) □ Shoe covers

- If yes, did you come into contact with the patient's body fluids? □ Yes □ No □ Unknown

If yes, which body fluids:

If yes, were you wearing PPE? □ Yes □ No □ Unknown

If yes, what type? Tick all that apply:

□ Medical mask □ Face shield □ Gloves □ Goggles/glasses □ Gown
□ Coverall □ Head cover □ Respirator (e.g. N95 or equivalent) □ Shoe covers

Have you had direct contact with the patient's materials since his/her admission? □ Yes □ No □ Unknown

Patient's materials: personal belongings, linen and medical equipment that the patient may have had contact with

- If yes, which materials? Tick all that apply:

□ Clothes □ Personal items □ Linen □ Medical devices used on the patient
□ Medical equipment connected to the patient (e.g. ventilator, infusion pump etc)
□ Other:

- If yes, how many times since his/her admission (total)?

- If yes, did you come into contact with the patient's body fluids via the patient's materials?
  □ Yes □ No □ Unknown

If yes, which body fluids:

If yes, were you wearing PPE? □ Yes □ No □ Unknown

If yes, what type? Tick all that apply:
□ Medical mask □ Face shield □ Gloves □ Goggles/glasses □ Gown
□ Coverall □ Head cover □ Respirator (e.g. N95 or equivalent) □ Shoe covers

- If yes, did you perform hand hygiene before contact with the patient's materials?

□ Always, as recommended □ Most of the time □ Occasionally □ Rarely

If yes: □ Alcohol-based hand rub □ Soap and water □ Water

- If you were wearing gloves, did you remove gloves after contact with the patient? □ Yes □ No

- If yes, did you perform hand hygiene after contact with the patient's materials?

□ Always, as recommended □ Most of the time □ Occasionally □ Rarely

If yes: □ Alcohol-based hand rub □ Soap and water □ Water

Have you had direct contact with the surfaces around the patient? □ Yes □ No □ Unknown

- If yes, which surfaces? Tick all that apply:

□ Bed □ Bathroom □ Ward corridor □ Patient table □ Bedside table □ Dining table □ Medical gas panel
□ Other:

- How many times since his/her admission (total)?	

- If yes, did you come into contact with the patient's body fluids via the surfaces around the patient?
  □ Yes □ No □ Unknown

If yes, which body fluids:

If yes, were you wearing PPE? □ Yes □ No □ Unknown

If yes, what type? Tick all that apply:
□ Medical mask □ Face shield □ Gloves □ Goggles/glasses □ Gown
□ Coverall □ Head cover □ Respirator (e.g. N95 or equivalent) □ Shoe covers

- If yes, did you perform hand hygiene after contact with these surfaces? □ Yes □ No □ Unknown

If yes: □ Alcohol-based hand rub □ Soap and water □ Water

Exposures to COVID-19 infected patient

Have you experienced any respiratory symptoms (sore throat, cough, running nose, shortness of breath) in the period since the patient has been admitted? □ Yes □ No If no, please skip symptoms sections

Date of first symptom onset (DD/MM/YYYY)	(DD/MM/YYYY)___/___/___ □ Asymptomatic □ Unknown
Fever (≥38 °C) or history of fever	□ Yes □ No □ Unknown If yes, specify maximum temperature:

Respiratory symptoms

Symptom	**Yes**	**No**	**Unknown**	**If Yes, date (DD/MM/YYYY): __/___/___**
Sore throat	□	□	□	

Cough	□	□	□				
Runny nose	□	□	□				
Shortness of breath	□	□	□				
Other symptoms							
Symptom	**Yes**	**No**	**Unknown**	**Symptom**	**Yes**	**No**	**Unknown**
Chills	□	□	□	Muscle aches	□	□	□
Vomiting	□	□	□	Joint ache	□	□	□
Nausea	□	□	□	Loss of appetite	□	□	□
Diarrhoea	□	□	□	Nose bleed	□	□	□
Headache	□	□	□	Fatigue	□	□	□
Rash	□	□	□	General malaise	□	□	□
Conjunctivitis	□	□	□	Other symptoms, specify			
Health care worker pre-existing condition(s)							
Condition	**Yes**	**No**	**Unknown**	**Condition**	**Yes**	**No**	**Unknown**
Obesity	□	□	□	Chronic liver disease	□	□	□
Cancer	□	□	□	Chronic kidney disease	□	□	□
Diabetes	□	□	□	Heart disease	□	□	□
HIV/other immune deficiency	□	□	□	Chronic neurological impairment/disease	□	□	□
Asthma (requiring medication)	□	□	□	Chronic haematological disorders	□	□	□
Chronic lung disease (non-asthma)	□	□	□	Organ or bone narrow recipient	□	□	□
Other pre-existing condition(s)				Specify			
Pregnancy	□	□	□	If yes, specify trimester: □ 1st □ 2nd □ 3rd □ NA Estimated delivery date (DD/MM/YYYY) _____/__/___			
Contact specimen collection (Day 1)							
Has baseline serum been taken?				□ Yes □ No □ Unknown If yes, specify date (DD/MM/YYYY):			
Which laboratory was the specimen sent to?							
Date sent to laboratory (DD/MM/YYYY)				_____/___/___			