V.2021.08.31

Human Infection with 2019 Novel Coronavirus

RESET FORM

Maven ID: _____
Interview Date: ____/_____/_____
Interviewed by Proxy*: ☐ Yes ☐ No
Proxy Name: _____
Proxy Relationship: _____

If patient has passed away, mark patient's death and end SF interview

Did the patient die as a result of this illness? ☐ Yes ☐ No ☐ Unknown If yes, date of death (MM/DD/YYYY): ____/_____/_____

Patient First Name:_____Patient Last Name:_____Date of Birth (MM/DD/YYYY):____/_____/_____
Address:_____Phone: (_____)_____-_____Email: _____
Resident Status: ☐ Resident ☐ Tourist* ☐ Active Military ☐ Military Dependent *If tourist, collect both address within Hawaii and out of state address*

Case Demographics

Is a translator / interpreter required?
☐ Yes ☐ No ☐ Unknown

If yes, specify which language:

_____

Gender: ☐ Male ☐ Female ☐ Other ☐ Unknown

Race (check all that apply):
☐ White
☐ Native Hawaiian
☐ Pacific Islander. Specify: _____
☐ Japanese
☐ Filipino
☐ Chinese
☐ Other Asian, specify: _____
☐ Black
☐ American Indian / Alaskan Native
☐ Other. Specify: _____

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

What is the patient's occupation/student status?
☐ Accommodation / Food Services
☐ Personal Care Services (Massage Therapists, Barber, Hairdresser, etc.)
☐ Correctional Officer / Correctional Facility Worker
☐ Other Occupation. Specify: _____
Workplace Name: _____
☐ Teacher / Educational Services Worker ☐ Student / Day Care
School / Day Care Name: _____
Grade / Class: _____
Last date at work/school prior to positive test? ____/_____/_____

Health Care Worker Information

Is the patient a health care worker in the United States? ☐ Yes ☐ No ☐ Unknown

If yes, what type of health care work?
☐ Direct Patient Care ☐ Other Health Care Work
If working directly with patients, respiratory therapist? ☐ Yes ☐ No

If yes, what is the patient's job setting?
☐ Hospital ☐ Hospice ☐ Adult Residential Care Home ☐ Other
☐ Assisted Living Facility ☐ Skilled Nursing Facility (SNF) ☐ Unknown

Symptoms, Hospitalization, ICU, and Death

Symptoms present during course of illness: ☐ Symptomatic ☐ Asymptomatic ☐ Unknown If case was symptomatic, onset date (MM/DD/YYYY): ____/_____/_____
If patient was symptomatic, symptoms: ☐ Fever ☐ Cough ☐ Shortness of Breath ☐ Loss of Smell ☐ Loss of Taste

Was the patient hospitalized for COVID-19*? ☐ Yes ☐ No ☐ Unknown
To be considered hospitalized, case must have spent at least one night within facility.
If yes, admission date (MM/DD/YYYY): ____/_____/_____
If yes, discharge date (MM/DD/YYYY): ____/_____/_____

Past Medical History

Did the patient have any underlying medical conditions and / or risk behaviors? ☐ Yes ☐ No ☐ Unknown

Diabetes	☐ Yes ☐ No ☐ Unknown	Chronic Lung Disease (Severe Asthma/Emphysema/COPD)	☐ Yes ☐ No ☐ Unknown
Chronic Renal Disease	☐ Yes ☐ No ☐ Unknown	Immunosuppressive Condition	☐ Yes ☐ No ☐ Unknown
Current Smoker / Vape User	☐ Yes ☐ No ☐ Unknown	Former Smoker / Vape User	☐ Yes ☐ No ☐ Unknown

Was the patient hospitalized for an illness other than COVID-19? ☐ Yes ☐ No ☐ Unknown Admission Date: ____/_____/_____ Discharge: ____/_____/_____

COVID-19 Testing

Why did the patient get tested? (referring to current positive test result) (check all that apply):

☐ Notified of potential exposure
- ☐ Close contact that tested positive
- ☐ Hawaii DOH
- ☐ AlohaSafe exposure notification app
- ☐ Other exposure notification app. Specify: _____
- ☐ Educational facility / school / daycare
- ☐ Other workplace
- ☐ Other notification source. Specify: _____

☐ Developed symptoms consistent with COVID-19

☐ COVID-19 screening program (pre-travel, pre-procedure, etc.)
- ☐ Pre-travel COVID-19 testing
- ☐ Pre-procedure or prenatal (medical) COVID-19 screening
- ☐ COVID-19 screening required by congregate residential setting (e.g., long-term care, care home, shelter)
- ☐ COVID-19 screening offered by a workplace
- ☐ COVID-19 screening offered for students at a school (e.g., preschool, K-12, or institute of higher education)
- ☐ Other COVID-19 screening program. Specify: _____

☐ General concern. Specify: _____

☐ Other reason. Specify: _____

Was patient already in isolation / quarantine prior to receiving a positive COVID-19 result?
☐ Yes ☐ No If yes, isolation start date: (MM/DD/YYYY): ____/_____/_____

COVID-19 Vaccination Information

Has patient received the COVID-19 vaccine? ☐ Yes ☐ No

If yes, 1st Dose Information:

Vaccine Manufacturer:
- ☐ Pfizer
- ☐ Moderna
- ☐ AstraZeneca/Oxford
- ☐ J&J (single dose)

Date Received First Dose (MM/DD/YYYY): ____ /_____ /_____

If applicable, 2nd Dose Information:

Vaccine Manufacturer:
- ☐ Pfizer
- ☐ Moderna
- ☐ AstraZeneca/Oxford

Date Received second Dose (MM/DD/YYYY): ____ /_____ /_____

Exposure Information

In the 14 days prior to illness onset, did the patient have any of the following exposures? (check all that apply):

Contact with a Known COVID-19 Case (Probable or Confirmed)

If the patient had contact with a known COVID-19 case, what type of contact?
- ☐ Household Contact
- ☐ Community - Associated Contact
- ☐ Healthcare - Associated Contact (Patient, Visitor, or Healthcare Worker)

Travel
- ☐ Interisland Travel. Specify Island(s): _____
- ☐ Mainland U.S. Travel. Specify State(s): _____
- ☐ International Travel. Specify Country(s): _____
- ☐ Close Contact with any Visitor from Outside Hawaii
- ☐ Cruise Ship or Vessel Travel (Passenger or Crew Member)

Congregate Settings
- ☐ Workplace
- ☐ Adult Congregate Living Facility (Nursing, Assisted Living, Care Facility)
- ☐ School / University / Childcare Center
- ☐ Correctional Facility / Detention Center
- ☐ Spas / Salons / Barbers
- ☐ Gym / Weight Room / Yoga or Dance Studio
- ☐ Community Event /Mass Gathering (Parties, Luaus, Weddings, Funerals)

☐ Other Exposures. Specify: _____

Additionally, **from the date 2 days prior to illness onset until now**, did the patient have any of the following exposures? (check all that apply):

Travel
- ☐ Interisland Travel. Specify Island(s): _____
- ☐ Mainland U.S. Travel. Specify State(s): _____
- ☐ International Travel. Specify Country(s): _____
- ☐ Close Contact with any Visitor from Outside Hawaii
- ☐ Cruise Ship or Vessel Travel (Passenger or Crew Member)

Congregate Settings
- ☐ Workplace
- ☐ Adult Congregate Living Facility (Nursing, Assisted Living, Care Facility)
- ☐ School / University / Childcare Center
- ☐ Correctional Facility / Detention Center
- ☐ Spas / Salons / Barbers
- ☐ Gym / Weight Room / Yoga or Dance Studio
- ☐ Community Event /Mass Gathering (Parties, Luaus, Weddings, Funerals)

Last date at congregate setting prior to positive test? ____ /_____ /_____

Identified Risk Factor*: ☐ Travel International ☐ Travel US ☐ Contact with Travelers ☐ Community

**As determined by answers to cases "Travel" questions and the "Identified Risk Factor Protocol" outlined within script*

Which best describes where the patient was staying at the time of illness onset?

Non-Congregate Housing
- ☐ House / Single Family Home / Apartment / Condo / Mobile Home

If non-congregate housing, number of individuals living within same housing unit: _____

Healthcare/Assisted Living

Specify:
- ☐ Long-Term Care Facility / Nursing Home
- ☐ Assisted Living Facility
- ☐ Skilled Nursing Facility (SNF)
- ☐ Acute Care Inpatient Facility
- ☐ Rehabilitation Facility
- ☐ Hospice

Congregate housing

Specify:
- ☐ Dormitory
- ☐ Homeless Shelter
- ☐ Hotel/Motel
- ☐ Correctional Facility
- ☐ Group Home
- ☐ Outside (Car / Other location not meant for habitation)

☐ Unknown

☐ Other. Specify: _____

Notes