COVID-19 Close Contact Interview Form

Florida Department of Health in Miami-Dade County
Epidemiology, Disease Control and Immunization Services (EDC-IS)
PH: 305-470-5660, FAX: 786-732-8714

Health Department Use Only
Merlin #: _____
Date of last exposure to COVID-19: _____

Notify the person of possible exposure to COVID-19, assess their medical condition and other risk factors, offer opportunity to answer questions and provide referrals for testing.

Interviewer's Name: _____ Interviewer's phone #: _____

Contact notified? ☐Yes, date: _____ Preferred language: ☐ English ☐ Spanish ☐ Other: _____

☐ No, document attempts below:

Attempt date: _____Outcome: ☐Requested call back ☐Left Message ☐No answer ☐Wrong number ☐Refused/Don't call back ☐No phone # available

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PROFILE DETAILS – Verify identity

1. Contact name: _____ DOB: _____

Phone #: _____ Email: _____

2. Home address and zip code: _____

3. Gender: ☐Male ☐Female, pregnant? ○No ○Yes

4. Race: ☐ American Indian/Alaska Native ☐Asian ☐Black ☐Native Hawaiian/Pacific Islander ☐White ☐Other ☐UNK

5. Ethnicity: ☐Hispanic ☐Non-Hispanic ☐UNK

CLINICAL INFORMATION – identify if contact needs medical evaluation

6. The contact was or is symptomatic? ☐ No ☐Yes, developed the following symptoms:

☐Dry cough, onset date: _____ ☐Chills, onset date: _____

☐Productive cough, onset date: _____ ☐Runny nose, onset date: _____

☐dyspnea/shortness of breath, onset date: _____ ☐Nausea, onset date: _____

☐Fever, highest temp (°F) _____, onset date: _____ ☐Diarrhea, onset date: _____

☐Muscles aches, onset date: _____ ☐Vomiting, onset date: _____

☐Headache, onset date: _____ ☐Abdominal pain, onset date: _____

☐Sore throat, onset date: _____ ☐Other: _____

☐New loss of smell or taste, onset date: _____ ☐Asymptomatic

7. If yes to #6, did contact seek medical care or require hospitalization? ☐ No ☐Yes, did contact get tested for COVID-19? ○ No ○Yes

8. Underlying health conditions:

Current smoker: ☐ No ☐Yes Chronic lung disease: ☐ No ☐Yes, Asthma? ○ No ○Yes COPD? ○ No ○Yes

Former smoker: ☐ No ☐Yes Chronic kidney disease: ☐ No ☐Yes

Obesity: ☐ No ☐Yes Chronic liver disease: ☐ No ☐Yes

Diabetes: ☐ No ☐Yes Cardiac disease: ☐ No ☐Yes

Hypertension: ☐ No ☐Yes Neurological/neurodevelopmental: ☐ No ☐Yes, specify: _____

Immunocompromised: ☐ No ☐Yes, specify: _____ Other: _____

ADDITIONAL INFORMATION

Group Setting

9. Contact lives or works in a group setting? ☐ No ☐ Yes, facility name: _____

Address: _____

10. Setting type:

☐ Behavioral/Mental Health Facility ☐ Camp ☐Correction Facility/Juvenile Detention Center

☐ Daycare, Adult ☐ Daycare, Child ☐ Hospice

☐ Independent living/retirement community ☐ Long Term Care Facility (ALF, Nursing Home, ICF/IID)

☐ Rehabilitation facility (substance abuse) ☐School, college/university ☐ School, primary or secondary private

☐ School, primary or secondary public ☐ Shelter ☐Other: _____

Employment/Attendance Information

11. Daycare: ☐ Attendance ☐ Staff ☐ No ☐ Unknown

12. What does the contact do for work (occupation): ☐ Farmer ☐ Food Handler ☐Health care worker ☐ No or non-sensitive
☐ Unknown ☐ Other: _____

What is the company name? _____ Phone #: _____

Last date contact was at work? _____

Other

13. Did contact travel to another county, state, or country during quarantine: ☐ No ☐Yes, by (circle): ○ car ○ flight ○ cruise

Location name: _____

14. Did contact get a COVID-19 test after the possible COVID-19 exposure:
☐ No ☐Yes, where/when: _____

Interviewer reviewed with the contact the CDC quarantine recommendations and preventive measures? ☐ No ☐Yes

- Self-quarantine means contact should stay home until _____(date). Not go to work and limit interactions with others.
- Assessed living situation: _____
- Addressed concerns: _____
- Established a plan for daily health monitoring: _____
- Discussed what to do if symptoms develop: _____

Comments: _____

_____

_____