



COVID-19 QUESTIONNAIRE - PROXY

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FORM CODE: COP
VERSION: 1.0 06/10/2020

Event: _____

0a) Date of Collection / /

0b) Staff Code

Instructions: This is a shortened version of the COVID-19 Questionnaire that should be completed by the coordinator while interviewing the participant's spouse or caretaker over the phone.

Interviewer: To help us better understand the health of study participants during the COVID-19 pandemic, we would like to ask you some questions about the participant's possible exposure to the coronavirus. The interview will take us as little as 5 minutes, or as much as 15 minutes, depending on whether the participant has been diagnosed with COVID-19. This information will be handled in the same way as the other data we have collected by phone, but you will be answering on his or her behalf.

1. Would it be okay to ask you questions about his/her COVID-19 related experiences today?

- No₀
- Yes₁ → **Go to 2**

1a. When would it be convenient to call back? / /

Interviewer: Thank you, we will call again. → End Form

2. May we also call you in the future to see how he/she is doing and ask you these questions again?

- No₀
- Yes₁

3. Has a healthcare provider ever told him/her that he/she had COVID-19?

- No₀ → **Go to 4**
- Yes, definitely₁
- Yes, probably or suspected₂

3a. Name of doctor/clinic/hospital: _____

3b. Street address of doctor/clinic/hospital: _____

3c. City of doctor/clinic/hospital: _____

3d. State of doctor/clinic/hospital: _____

3e. Zip code of doctor/clinic/hospital: _____

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3f. Contact number of doctor/clinic/hospital: - -

4. Did he/she have symptoms of COVID-19?

- No₀
- Yes₁
- Unsure₂

5. Did he/she have a positive test for COVID-19?

- No₀
- Yes₁
- Unsure₂

6. Did he/she have close contact with someone who had COVID-19?

- No₀
- Yes₁
- Unsure₂

7. Has he/she been tested for coronavirus or COVID-19?

- No₀
- Yes₁
- Unsure₂

8. Has he/she had an overnight stay in a hospital for suspected or diagnosed COVID-19?

- No₀ → **End Form**
- Yes₁
- Unsure₂ → **End Form**

9. Approximately how many nights in the hospital? nights

9a. Date arrived: / /

9b. Is he/she still in the hospital?

- No₀
- Yes₁ → **Go to 10**

9c. Date discharged: / /

10. During the hospital stay, did he/she ever require oxygen by nasal cannula (in his/her nose)?

- No₀
- Yes₁
- Unsure₂

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11. During the hospital stay, did he/she ever require oxygen by face mask?

- No₀
- Yes₁
- Unsure₂

12. During the hospital stay, did he/she ever require "Intensive Care Unit" (ICU) monitoring?

- No₀
- Yes₁
- Unsure₂

13. During the hospital stay, did he/she ever require a breathing tube or ventilator?

- No₀
- Yes₁
- Unsure₂

14. During the hospital stay, did he/she ever require "ECMO" treatment?

- No₀
- Yes₁
- Unsure₂

15. Address:

15a. Name of hospital: _____

15b. Street address of hospital: _____

15c. City of hospital: _____

15d. State of hospital: _____

15e. Zip code of hospital: _____

15f. Contact number of hospital: - -

16. When he/she was discharged, was he/she discharged to:

- Home₁ → **End Form**
- Nursing facility₂ → **End Form**
- Other₃
- Still in hospital₄ → **End Form**

16a. If other, please specify: _____

END OF FORM