A SERO-SURVILLANCE STUDY FOR COVID-19 DISEASE IN HEALTH CARE WORKERS

* Required

1. Identifier and risk assessment information

1. 1.1 Full Name *

____

2. 1.2 Staff number *

____

3. 2.Sex *

Mark only one oval.

( ) Male
( ) Female

4. 3.Date of Birth *

____
Example: January 7, 2019

5. 4.Mobile number *

____

6. 5.Governorate *

Mark only one oval.

- Muscat
- Dhofar
- Dakhliyah
- Al Dhahirah
- North Batinah
- South Batinah
- North Sharqiyah
- South Sharqiyah
- Musandm
- Al Buraimi
- Al Wusta

7. 6.Wilayt of residency *

8. 7.Nationality *

9. 8.Hospital *

10. 9.Occupation in health care facility *

Mark only one oval.

- Medical doctor
- Nurse
- Lab Technician
- Radiology/x-ray technician
- Phlebotomist
- Nutritionist/dietician
- pharmacist
- medical orderly
- Cleaner
- Administration
- medical engineer
- IT personal
- Others

11. 10.Residence/accommodation place *

Mark only one oval.

- Hospital campus
- Renting with friends
- Company residential complex
- Family house

12. 11.Number of people living in the same accommodation *

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13. 12.Number of people sharing room *

____

14. 13.Have you recently had Infection prevention & control (IPC) training ? *

Mark only one oval.

- ( ) Yes
- ( ) Forgotten/not sure
- ( ) I never had IPC training

15. 14.If Yes to Q13,What was the date of your most recent IPC training within the health care facility?

____

Example: January 7, 2019

16. 15.Are you a healthcare worker specifically dedicated to caring for COVID-19 patients? *

Mark only one oval.

- ( ) YES
- ( ) NO
- ( ) There are no COVID-19 dedicated staff in my facility

17. 16.Have you had contact with anyone with probable or confirmed COVID-19 virus infection? *

Mark only one oval.

- YES
- NO
- UNKNOWN

18. 17.If yes to Q16 , the person was

Mark only one oval.

- Patient
- Co-worker
- Friend
- Family member

19. 18.If Yes to Q16, dates of last contact

____

Example: January 7, 2019

20. 19.If yes to Q16, did you wear PPE?

Mark only one oval.

- YES
- NO
- UNKNOWN

21. 20.If yes to Q19, what type? (list is multiple choice)

Check all that apply.

- [ ] Medical/surgical mask
- [ ] Face shield
- [ ] Gloves
- [ ] Goggles/glasses
- [ ] Gown
- [ ] Coverall
- [ ] Head cover
- [ ] Respirator (e.g. N95, FFP2 or equivalent)
- [ ] Shoe covers

22. 21.If you were wearing a respirator (N95), was it test fitted?

Mark only one oval.

- YES
- NO
- UNKNOWN
- Not applicable

23. 22.If you were wearing gloves, did you remove them after contact with the patient? *

Mark only one oval.

- YES
- NO
- UNKNOWN
- Not applicable

24. 23.Were you present for any aerosolizing procedures performed on suspected/confirmed COVID-19 patient? *

Mark only one oval.

- YES
- NO
- UNKNOWN
- Not applicable

25. 24.If yes to Q23 , describe the procedure

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____

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____

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26. 25.If yes to Q23, did you wear PPE?

Mark only one oval.

- YES
- NO
- UNKNOWN

27. 26.If yes to Q25, what type?

Check all that apply.

- [ ] Medical/surgical mask
- [ ] Face shield
- [ ] Gloves
- [ ] Goggles/glasses
- [ ] Gown
- [ ] Coverall
- [ ] Head cover
- [ ] Respirator (e.g. N95, FFP2 or equivalent)
- [ ] Shoe covers

28. 27.If yes to Q23, was procedure performed in an airborne setting?

Mark only one oval.

- ( ) Yes
- ( ) No
- ( ) UNKNOWN

2. Disease / Symptom history

29. 1.Have you been confirmed to have COVID-19 before *

Mark only one oval.

- ( ) Yes
- ( ) No

30. 1.1 If yes , when was your test positive ?

____

Example: January 7, 2019

31. 1.2 If yes to Q1, Have you had radiological evidence of pneumonia (e.g. by chest X-ray or computed tomography scan) since diagnose?

Mark only one oval.

- Yes
- No
- UNKNOWN

32. 1.3 If yes to Q1, did you require admission?

Mark only one oval.

- Yes
- No

33. 1.4 If Yes, did you need ICU care?

Mark only one oval.

- Yes
- No

34. 1.5 How long admission?

____

35. 1.6 Outcome? (Full recovery or with Sequel)

____

____

____

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36. 2. Do you recall any of the following symptoms in the past 4-12 weeks? *

Mark only one oval per row.

	YES	NO	UNKNOWN
Fever ≥38°C	⬭	⬭	⬭
Fatigue	⬭	⬭	⬭
Muscle ache (myalgia)	⬭	⬭	⬭
Sore throat	⬭	⬭	⬭
Cough	⬭	⬭	⬭
Runny nose (rhinorrea)	⬭	⬭	⬭
Shortness of breath (dyspnea)	⬭	⬭	⬭
Wheezing	⬭	⬭	⬭
Chest pain	⬭	⬭	⬭
Other respiratory symptoms	⬭	⬭	⬭
Headache	⬭	⬭	⬭
Nausea/vomiting	⬭	⬭	⬭
Abdominal pain	⬭	⬭	⬭
Diarrhea	⬭	⬭	⬭

37. 3.Do you have any underlying disease or pre-existing condition(s)? (list is multiple choice) *

Check all that apply.

- [ ] Pregnancy
- [ ] Obesity
- [ ] Cancer
- [ ] Diabetes
- [ ] Hypertension
- [ ] HIV/other immune deficiency
- [ ] Heart disease
- [ ] Asthma (requiring medication)
- [ ] Chronic lung disease (non-asthma)
- [ ] Chronic liver disease
- [ ] Chronic haematological disorder
- [ ] Chronic kidney disease
- [ ] Chronic neurological
- [ ] Organ/bone marrow recipient
- [ ] NO
- [ ] UNKNOWN

Other: [ ] ______________________

38. 4.Are you taking any medication(s) regularly ? (list is multiple choice) *

Check all that apply.

- [ ] Statin medication
- [ ] ACE inhibitors
- [ ] Anti-acid
- [ ] Proton pump inhibitors (Omeprazole)
- [ ] Steroid medication
- [ ] Antidiabetic medication
- [ ] Immunosuppressive medication
- [ ] No
- [ ] Unknown

Other: [ ] ______________________

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