


Sample CAC data collection form

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|  <p><b>COVID-19 ASSESSMENT CENTRE<br/>MOBILE OUTREACH TESTING<br/>COVID-19 PATIENT ASSESSMENT FORM</b></p>  | <p><b>AFIX PATIENT LABEL</b></p>   |
| <p>Date: _____ Time: _____</p>   |  |
| <p><b>SHELTER INFORMATION</b></p>  |  |
| <p>Shelter name: Seaton House<br/>Location within shelter: Winter Program</p>  |  |
| <p><b>In the last 14 days, have you:</b></p> <p>Visited another shelter or drop in program?      Y/N, if yes, location: _____</p>  |  |
| <p><b>SYMPTOMS</b></p>   |  |
| <p><input type="checkbox"/> <b>YES:</b></p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Shortness of Breath</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Other</p>  | <p><input type="checkbox"/> <b>No</b></p>  |
| <p><b>TESTING</b>      <input type="checkbox"/> YES      <input type="checkbox"/> No _____</p>   |  |
| <p><b>CLIENT INFORMATION (optional):</b></p>   |  |
| <p>To learn more about this virus, can we ask you questions about your health and demographics?<br/><input type="checkbox"/> YES   <input type="checkbox"/> NO</p>   |  |
| <p><b>Past Medical History:</b></p> <p><input type="checkbox"/> Cardiovascular disease</p> <p><input type="checkbox"/> Chronic lung disease</p> <p><input type="checkbox"/> HIV</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Current Smoker</p> <p><input type="checkbox"/> Mental Health diagnosis: _____</p> <p><input type="checkbox"/> Substance Use disorder: _____</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Prefer not to disclose</p> | <p><b>Racial or Ethnic Identity:</b></p> <p><input type="checkbox"/> Black</p> <p><input type="checkbox"/> East/Southeast Asian</p> <p><input type="checkbox"/> Indigenous (First Nations, Métis, Inuit)</p> <p><input type="checkbox"/> Latino</p> <p><input type="checkbox"/> Middle Eastern</p> <p><input type="checkbox"/> South Asian (Indian, Pakistani)</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Prefer not to disclose</p> |
| <p><b>ADDITIONAL NOTES:</b></p>  |  |
| <p>Do you consent to be contacted by a research team member for future research opportunities?<br/><input type="checkbox"/> YES   <input type="checkbox"/> NO</p>  |  |
| <p>Staff Name: _____</p>   | <p>Staff Signature: _____</p>  |

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