COVID-19 Offender Questionnaire for Entry into DOC Facility

This screening questionnaire is intended to prevent the spread of COVID-19 and reduce the potential risk of exposure to employees, offenders, volunteers, visitors, families and public. Your participation is an important precautionary measure as offenders move from jails to VADOC facilities. This form MUST be completed for all offenders prior to transportation to a DOC facility.

Offender Name:	**Offender's DOC Number:**
Date of Birth:	**Jail:**

1.	Has the offender had close contact with someone diagnosed with COVID-19 within the last 14 days? ☐ Yes ☐ No
2.	Has the offender had COVID-19? ☐ Yes ☐ No If so, when? _____
3.	Has the offender ever had a COVID-19 test?_____ If so, when?_____Results_____ Repeat test date_____Results_____ Repeat test date_____Results_____
4.	Has the offender experienced any of the following symptoms in the last 14 days? Fever or sense of fever ☐ Yes ☐ No Cough ☐ Yes ☐ No Sore Throat ☐ Yes ☐ No Congestion or Runny Nose ☐ Yes ☐ No Shortness of breath or Difficulty breathing ☐ Yes ☐ No Fatigue ☐ Yes ☐ No Chills or Repeated shaking with chills ☐ Yes ☐ No Muscle pain ☐ Yes ☐ No Headache ☐ Yes ☐ No New loss of taste or smell ☐ Yes ☐ No Nausea or Vomiting ☐ Yes ☐ No Diarrhea ☐ Yes ☐ No Abdominal pain ☐ Yes ☐ No If the offender has any of the above mentioned symptoms, what is the onset date of first symptoms: _____
5.	Is the offender currently under doctor's care for any illness? ☐ Yes ☐ No If YES please explain. Does he need follow-up care?

6.	Is the offender insulin dependent? ☐ Yes ☐ No
7.	Has the offender had any incidents of self-injurious behavior or suicide attempts requiring outside medical intervention or homicidal ideation during the past 12 months? ☐ Yes ☐ No
8.	Is the offender currently seeing a mental health provider or therapist? ☐ Yes ☐ No If YES: How often does the offender see the provider/therapist? _____
9.	Is the offender currently taking any medications? ☐ Yes ☐ No List medications:
10.	Have any of the offender's medications changed over the past 60 days? ☐ Yes ☐ No Name of medication: _____
11.	Does the offender have any pending court matters? (e.g. juvenile and domestic, general district, circuit court?) ☐ Yes ☐ No
12.	Is the offender currently eligible for or being considered for HEM? ☐ Yes ☐ No

Jail/Medical Staff: _____ Date:_____

Jail Staff: Please follow these instructions based on completion of your review of the offender:

- If the answer is "**Yes**" to <u>any</u> of the above questions, please notify the requesting Intake Section employee ASAP.
- If the answer is "**No**" to <u>all</u> of the above questions, please scan and email this completed form to the requesting Intake Section employee. Please note the date and time of your scan/email here:
    - Scan/email date: _____
    - Scan/email time: _____