SARS-CoV-2 Seroprevalence

Please complete the brief survery.

Study interest and consent: Click below to begin the survey. In doing so, you agree to participate in the survey and to the use of your survey responses as described in the email correspondence. All information will be managed according to the Metro Health IRB privacy and confidentiality policies. If you do not wish to participate please click on the not interested link below.	◯ Not interested ◯ Interested

Section 1 (Demographics)

AGE	_____
Gender	◯ Male ◯ Female ◯ Other
Race/Ethnicity	◯ Caucasian ◯ Hispanic-Latino ◯ Black-African American ◯ Asian-Pacific Islander ◯ Arabic / Middle Eastern ◯ Other

Section 2 (Exposure Risk since MARCH 1st 2020)

Have you been diagnosed with active COVID-19 (PCR/Antigen test)?	◯ Yes ◯ No
What date were you diagnosed with COVID-19?	_____
Have you been tested for SARS-CoV-2 antibodies in the past (Including the PRIOR Metro-UM survey/Lab draw or any other laboratory)?	◯ Yes ◯ No
Approximately when were you tested? (check ALL that apply if more than one test was done)	☐ 1 Month ago ☐ 2 Months ago ☐ 3 Months ago ☐ 4 Months ago ☐ 5 Months ago ☐ 6 Months ago ☐ 7 Months ago ☐ 8 Months ago
Were any of the prior antibody tests positive?	◯ positive ◯ negative / unsure
Did any household members have antibody testing?	◯ Yes ◯ No
Were they seropositive?	◯ Yes ◯ No

In retrospect, do you recall any symptoms that could have been associated with COVID-19?	☐ None ☐ Fever ☐ Myalgias (muscle aches) ☐ Sore throat ☐ Runny nose ☐ Loss of smell or taste ☐ Cough ☐ Shortness of breath ☐ Unusual headaches ☐ Diarrhea or upset stomach ☐ Fatigue ☐ Other
Please tell us what symptoms you experienced if not listed?	_____
Did you ever quarantine for suspected COIVD-19 or contacts?	◯ Yes ◯ No
Have you experienced any symptoms that you believe may be consistent with COVID-19 disease? (check any that apply)	☐ None ☐ Fever ☐ Myalgias (muscle aches) ☐ Sore throat ☐ Runny nose ☐ Loss of smell or taste ☐ Cough ☐ Shortness of breath ☐ Unusual headaches ☐ Diarrhea or upset stomach
Have you practiced social distancing, wearing masks, frequent hand washing, stay at home orders and other safety measures outlined by the Michigan Department of Health and Human Services?	◯ Usually ◯ Sometimes ◯ Rarely
Have you worked in the Metro Health System since March 1st 2020?	◯ Full time ◯ Part time
Have you been exposed to someone OUTSIDE of work and NOT living in your household with known or suspected COVID-19 infection for > 15 minutes in one 24 hour period?	◯ Yes ◯ No
Have you been exposed to someone living in your household with known or suspected COVID-19?	◯ Yes ◯ No
Have you worn appropriate PPE while at work without known violations to your PPE policy?	◯ Yes ◯ No ◯ Sometimes
When required which enhanced respiratory protective device did you wear?	◯ N95 masks ◯ CAPRs ◯ Mix of N95 masks and CAPRs ◯ Not involved in aerosol generating procedures ◯ Not applicable to my role

What is your primary role at Metro Health? (choose best answer)

◯ Physician (Attending) Inpatient
◯ Physician (Attending) Clinic
◯ Physician (Attending) Inpatient + Outpatient
◯ Physician (intern/resident/fellow)
◯ Advanced Practice Provider (Inpatient)
◯ Advanced Practice Provider (Outpatient)
◯ Advanced Practice Provider (Inpatient + Outpatient)
◯ Nurse (Inpatient)
◯ Nurse (Outpatient)
◯ MA (Clinic)
◯ Radiology Tech or support (Inpatient)
◯ Radiology Tech or support(Outpatient)
◯ Respiratory therapist
◯ Lab/Phlebotomy
◯ Nutrition / RD
◯ Social work, case management
◯ PT/OT/SLP
◯ Cafeteria / Food services
◯ Unit clerks / Clerical (Inpatient)
◯ Clerical (Outpatient)
◯ Research
◯ Administrative
◯ Housekeeping / Janitorial
◯ Pharmacy
◯ Security
◯ Cancer Center
◯ other (type in)

Describe your role if not listed?

_____

What best describes your perceived exposure to COVID-19 while at work?

◯ High ◯ Moderate ◯ Low

Check all that apply

☐ Patient exposures ☐ Colleague exposures ☐ Visitor exposures
☐ Perceived lack of appropriate PPE or infection prevention policies
☐ other (type in)

Why do you perceive your risk of exposure to COVID-19 at work to be "High"?

_____

Which floor/unit is your primary unit where you spend most of your clinical time since March 1 2020?

◯ ED
◯ PACU/SPR
◯ OR
◯ Level 2
◯ CBC
◯ ABC
◯ Level 3
◯ Level 4 PCU
◯ Level 4 ICU
◯ Level 5
◯ Level 6
◯ Lab
◯ Multiple Units/entire hospital
◯ Outpatient Clinic
◯ Cancer Center
◯ Non-Clinical Area
◯ Other

Unit- Please type in where you work if not listed above? _____