Office for National Statistics

IQVIA

COVID-19 INFECTION SURVEY: CRF2 INDIVIDUAL PARTICIPANT – COMPLETE AT EACH VISIT FOR EACH CONSENTING PARTICIPANT

Unique house-hold code												Participant suffix		Participant date of birth	D	D	M	M	M	Y	Y	Y	Y

Date/time of visit	D	D	M	M	M	Y	Y	Y	Y		h	h	:	m	m	Timing of visit	☐Enrolment ☐Follow-up	Type of visit	☐Contact ☐Non-contact

Swab taken	☐Yes ☐No	If yes: barcode									If yes: shipment ID													
Blood taken	☐Yes ☐No	If yes: barcode									If yes: shipment ID													

Date/time samples taken	D	D	M	M	M	Y	Y	Y	Y		h	h	:	m	m

A: WORK

3. Working status (main job) ☐ Employed ☐ Self-employed ☐ Furloughed (temporarily not working) ☐ Not working (unemployed, retired, long-term sick etc.) ☐ Student

4. Do you currently work in healthcare?
   - ☐ No
   - ☐ Yes, primary care, patient-facing
   - ☐ Yes, primary care, non-patient-facing
   - ☐ Yes, secondary care, patient-facing
   - ☐ Yes, secondary care, non-patient-facing
   - ☐ Yes, other healthcare, patient-facing
   - ☐ Yes, other healthcare, non-patient-facing

5. Do you currently work in social care?
   - ☐ No
   - ☐ Yes, care/residential home, resident-facing
   - ☐ Yes, care/residential home, non-resident facing
   - ☐ Yes, other social care, resident-facing
   - ☐ Yes, other social care, non-resident-facing

6. Job title of main job or business (*for example, primary school teacher, car mechanic, district nurse, structural engineer etc.)*

7. What you mainly do in your main job or business? *(please describe as fully as possible. For example, please indicate if you have any management responsibilities)*

8. Where are you currently working? ☐ Working from home ☐ Working outside of your home ☐ Both (working from home and working outside of your home) ☐ Not applicable

9. How many days a week are you working outside your home? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ Not applicable

B: HEALTH STATUS TODAY

1. Do you have any of the following symptoms TODAY? ☐ Yes ☐ No If yes, complete presence/absence for each one

Symptom	Yes	No	Symptom	Yes	No
Fever	☐	☐	Headache	☐	☐
Muscle ache (myalgia)	☐	☐	Nausea/vomiting	☐	☐
Fatigue (weakness/tiredness)	☐	☐	Abdominal pain	☐	☐
Sore throat	☐	☐	Diarrhoea	☐	☐
Cough	☐	☐	Loss of taste	☐	☐
Shortness of breath	☐	☐	Loss of smell	☐	☐

2. Are you personally currently self-isolating? (meaning you are not leaving your home because you have/have had symptoms of coronavirus or live with someone who has symptoms)? ☐ Yes ☐ No
3. Have you personally received a shielding letter from the NHS? ☐ Yes ☐ No
4. Do you personally think you have symptoms consistent with COVID-19? ☐ Yes ☐ No

C: CONTACTS

1. Have you been in contact with someone that you definitely know (based on a test result) was infected with COVID-19 at the time? ☐ Yes ☐ No
   - i. If yes: Date of last contact of this type: D D M M M 2 0 2 Y
   - ii. Was this last person you had this type of contact with ☐ in your own household ☐ outside your household
2. Have you been in contact with someone that you think (no test result) was infected with COVID-19 at the time? ☐ Yes ☐ No
   - i. If yes: Date of last contact of this type: D D M M M 2 0 2 Y
   - ii. Was this last person you had this type of contact with ☐ in your own household ☐ outside your household
3. Have you, or anyone in your household, been in a hospital at all in the last two weeks for any reason (e.g. work, visiting, taking someone else or due to illness)?
   ☐Yes, I have ☐No I haven't, but someone else in my household has ☐No, no one in my household has
4. Have you, or anyone in your household, been in a care/residential home at all in the last two weeks for any reason (e.g. work, visiting, taking someone else or due to illness)?
   ☐Yes, I have ☐No I haven't, but someone else in my household has ☐No, no one in my household has

D: COVID-19 INFECTION

1. Do you think you have had COVID-19? ☐ Yes ☐ No
   - i. If yes: Date of first symptoms: D D M M M 2 0 2 Y
   - ii. Which symptoms did you have?

Symptom	Yes	No	Symptom	Yes	No
Fever	☐	☐	Headache	☐	☐
Muscle ache (myalgia)	☐	☐	Nausea/vomiting	☐	☐
Fatigue (weakness/tiredness)	☐	☐	Abdominal pain	☐	☐
Sore throat	☐	☐	Diarrhoea	☐	☐
Cough	☐	☐	Loss of taste	☐	☐
Shortness of breath	☐	☐	Loss of smell	☐	☐

   - iii. Did you contact the NHS about this infection? ☐ Yes ☐ No

     If yes
     a. Were you tested? ☐ Yes ☐ No
     b. Was the test result ☐ Positive ☐ Negative
     c. Were you admitted to hospital? ☐ Yes ☐ No

COMPLETED BY: Name	Signature	Date
		D D M M M 2 0 2 Y