**Disclaimer:** The Epi CASE Toolkit was developed by ATSDR as a guide to help state, local, tribal, and territorial health departments to quickly assess members of a community who have been impacted by a catastrophic incident.  The Epi CASE Toolkit is intended for health departments to use for their own public health purposes.

On request, ATSDR may provide technical assistance.

**Epi CASE TOOLKIT CONSENT FORM and SURVEY**

Hello, my name is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Public Health Department is conducting this survey to learn more about the [name of incident, disaster, or emergency], which we are calling the INCIDENT. We are asking you to take part in this survey because you were in the area of the [description of the disaster] or might have been exposed to [the name of chemical/radiological/nuclear/biological substance].

**Purpose:** The information we collect with this survey will help us learn who was affected by the incident.

If you take part in the survey, we might be able to help you get connected to services or receive helpful information. Your answers also help scientists better understand the incident, the community, and any health effects that might be related to the incident.

**Voluntary:** Taking part in the survey is voluntary. You can choose if you want to be interviewed. You can stop the interview at any time. You can also refuse to answer any question. If you refuse, it will not affect any government benefits that you might receive.

**Survey contents:** The survey will take about 5 minutes to answer. We will ask you questions about

* how to contact you and people you trust,
* where you were during the incident or how you might have been exposed,
* if you got injured or ill as a result of the incident,
* your immediate needs so we can connect you to the appropriate services, and
* your Social Security number, your driver’s license number, or another state identification that will be kept confidential in our database.

**Confidentiality:** Your information will be kept confidential to the fullest extent of the law. We will carefully and completely destroy all your specific answers after we finish working with those. Only authorized persons will have access to your information. Nothing will be published that can identify you.

Do I have your permission to ask you questions? 🞏 Yes 🞏 No

Do I have permission to contact you again in the future if we can provide you information or services or to gain more detailed information from you? You are still eligible to take part in this survey if you say no to future contact. 🞏 Yes 🞏 No

Reason for refusal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have any questions about this investigation, you can call the [this will more likely be the state or local health department] program at (XXX) XXX-XXXX.

By signing below, you agree to take part in the registry. You are also saying that we have given you a copy of this consent form. If any part of this form is not clear to you, please be sure to ask about it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Signature Date*

**If participant is a** **minor aged 13−17 years:**

As the parent/legal guardian for the above signed, I give my permission for him/her to take part in this survey.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Parent/Guardian Signature Date*

 Version 08262019

 INCIDENT CODE:|\_\_\_|\_\_\_| SITE # |\_\_\_|\_\_\_| INTERVIEWER ID|\_\_\_|\_\_\_|\_\_\_| DATE:|\_\_\_|\_\_\_| - |\_\_\_|\_\_\_ | - |\_\_\_|\_\_\_|\_\_\_|\_\_\_| Registrant ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 TIME STARTED |\_\_\_|\_\_\_| : |\_\_\_|\_\_\_ | |\_\_\_| TIME ENDED |\_\_\_|\_\_\_| : |\_\_\_|\_\_\_ | |\_\_\_| M M D D Y Y Y Y

 H H M M A/P H H M M A/P

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| --- | --- |
| **IDENTIFICATION PROVIDED** |  |
| * **Social Security \_ \_ \_ - \_ \_- \_ \_ \_ \_**
* Driver’s license: State \_\_ \_\_ Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_exp \_\_ / \_\_/ \_\_ \_\_\_\_
 | * State ID: State \_\_ \_\_

Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_exp \_\_ / \_\_/ \_\_ \_\_\_\_* Other ID (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **REGISTRANT PERSONAL INFORMATION** |
| **1. Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Last First M.I.**2.** **Date of Birth (mm/dd/yyyy)** \_ \_/\_ \_ /\_ \_ \_ \_  | **5. Social media account (check all that apply and specify)**Facebook  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞏Twitter \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞏Instagram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞏Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞏 Refused 🞏 |
| **3. A. Street** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **B.** How many children younger than 13 years were in your immediate care during the incident? \_\_\_\_\_\_\_ If 1 or more, complete Question 19 AFTER completing Questions 4–18. | **6. What are the best telephone numbers to reach you?****A**. (\_ \_ \_ ) \_ \_ \_ -\_ \_ \_ \_ Cell 🞏 Home 🞏 Work 🞏B. (\_ \_ \_ ) \_ \_ \_ -\_ \_ \_ \_ Cell 🞏 Home 🞏 Work 🞏 |
| **4. Email** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **7. Sex (circle one)** Male Female Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**8. If female, (circle one)** Pr**e**gnant Not pregnant Don’t know/refused  |
| **EMERGENCY CONTACT INFORMATION** (**Must live at a different address than registrant)** |
| **9. Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , \_\_\_\_\_\_\_\_\_\_\_ , \_\_\_\_\_  **(Last, First, M.I.)**  | **11. Email** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **10. Street address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_ \_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **12. What are the best telephone numbers to reach them?****A**. (\_ \_ \_ ) \_ \_ \_ -\_ \_ \_ \_ Cell 🞏 Home 🞏 Work 🞏B. (\_ \_ \_ ) \_ \_ \_ -\_ \_ \_ \_ Cell 🞏 Home 🞏 Work 🞏 |
| **EXPOSURE INFORMATION on [DATE] at [TIME]**  |
| **13**. **Were you exposed to this incident as**  **(check all that apply):**🞏 Facility employee (if applicable) 🞏 Passerby 🞏 First responder 🞏 Clean-up worker or volunteer 🞏 Government official (including military)🞏 Resident **Skip to Question 15**🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **14.** **A.** **Street address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **B.** **Nearest intersection/building/landmark**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 |
| **15. Physical location (check all that apply)** 🞏 Inside building 🞏 Outside 🞏 Inside a car/vehicle 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **HEALTH/NEEDS** |
| **16. As a result of this incident, did** **you get injured or ill? *Refer to Epi CASE Symptom Checker for codes***🞏Yes 🞏 No 🞏 Don’t know/refused  | **17. As a result of this incident, are you personally in need of anything? (check all that apply)**🞏Medicine or medical supplies 🞏 Medical care🞏 Mental health care 🞏 Water 🞏 Shelter 🞏 Food 🞏 Utilities 🞏 Transportation 🞏 Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞏 Don’t know/refused |
| **18. For radiological and nuclear incidents only: If you had repeated vomiting AFTER the incident, how long after the incident [date and time] did it start? (circle one)**  **less than 1 hour 1-2 hours**  **3-6 hours more than 6 hours**  **Did not vomit**  **Don’t know/Refused** |
| **CHILDREN YOUNGER THAN 13 YEARS IN YOUR IMMEDIATE CARE DURING THE INCIDENT** |
| **19. For each child, please provide the date of birth *or* age, sex, and injuries or illness that resulted from this incident. *Refer to the Epi CASE Symptom Checker for codes.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Date of birth (mm/dd/yyyy)**  | **Age****(years)** | **Sex (circle one)**  | **Child’s injury or illness** |
| 1. | \_\_/\_ \_ /\_ \_ \_ \_ | \_\_\_\_\_ | Male Female |  |  |  |  |  |
| 2. | \_\_/\_ \_ /\_ \_ \_ \_ | \_\_\_\_\_ | Male Female |  |  |  |  |  |
| 3. | \_\_/\_ \_ /\_ \_ \_ \_ | \_\_\_\_\_ | Male Female |  |  |  |  |  |
| 4. | \_\_/\_ \_ /\_ \_ \_ \_ | \_\_\_\_\_ | Male Female |  |  |  |  |  |
| 5. | \_\_/\_ \_ /\_ \_ \_ \_ | \_\_\_\_\_ | Male Female |  |  |  |  |  |

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