DHCW Consent To Participate In A Research Study

Consent Page 1

Consent Page 2

Consent Page 3

Consent Page 4

Consent Page 5

Consent Page 6

Consent Page 7

Indicate you agree or do not agree to participate in this research study.

◯ I Agree
◯ I Do Not Agree

Subject First Name

_____

Subject Last Name

_____

Subject Consent Signature

_____

Date of Subject Signature

_____
(mm/dd/yy)

e-Mail Address to Send Copy of Consent

_____

DHCW Start of Study Survey

Subject Study ID _____

Study Name: PREDICT- Pragmatic Return to Effective Dental Infection Control through Triage and Testing

Subject Name: [consent_arm_1][name_last], [consent_arm_1][name_first]

Date of Start of Study Survey _____

COVID-19 EXPERIENCE AND VACCINATION

Have you ever been diagnosed with COVID-19 as a result of a SARS-CoV-2 test?
- ◯ Yes
- ◯ No but I was told by a physician that I likely had COVID-19
- ◯ No
- ◯ Not Sure

If you were diagnosed with COVID-19, when were you diagnosed?
- ◯ January 2020 to March 2020
- ◯ April 2020 to June 2020
- ◯ July 2020 to September 2020
- ◯ October 2020 - December 2020
- ◯ January 2021- March 2021
- ◯ April 2021 - June 2021
- ◯ July 2021 - December 2021
- ◯ Don't Remember

Has one or more co-workers in your practice ever been diagnosed with COVID-19?
- ◯ No
- ◯ Yes
- ◯ Not sure

Has anyone that you live with ever been diagnosed with COVID-19?
- ◯ No
- ◯ yes
- ◯ Not Sure

Have you been vaccinated against COVID-19?
- ◯ No
- ◯ Yes
- ◯ Not Sure

If you have not been vaccinated, do you plan on obtaining the vaccination?
- ◯ No
- ◯ Not Sure
- ◯ Yes

How many doses have you received?
- ◯ One
- ◯ Two
- ◯ Three
- ◯ Don't Remember

When did you receive the first dose?

- ◯ June 202 - December 2020
- ◯ ,January 2021 - March 2021
- ◯ April 2021 - June 2021
- ◯ July 2021 - September 2021
- ◯ October 2021 - December 2021
- ◯ Don't Remember

Which vaccine did you receive?

- ◯ Pfizer
- ◯ Moderna
- ◯ Johnson and Johnson
- ◯ AstraZeneca
- ◯ Other
- ◯ Don't Remember

CONCERN

How concerned are you with:

	Not Concerned at All	Mild Concern	Moderate Concern	Severe Concern
a. getting sick from patients?	◯	◯	◯	◯
b. getting sick from your office co-workers?	◯	◯	◯	◯

DEMOGRAPHICS

What is your sex?

- ◯ Male
- ◯ Female
- ◯ Other

What is your date of birth?

_____

Are you of Hispanic or Latino origin?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

What racial category best describes you?

- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ Black or African_American
- ◯ White or Caucasian
- ◯ More than one race
- ◯ Prefer not to answer

Indicate your highest level of formal education:

- ◯ Less than high school diploma
- ◯ High school diploma or GED
- ◯ Some College/Associate degree
- ◯ Bachelor's degree
- ◯ Graduate degree

How would you describe the community where you live?

- ◯ Urban
- ◯ Suburban
- ◯ Rural

What is the zip code where you live?

_____

Including you, how many people live in your household?	_____
What is your family's current annual household income from all sources?	◯ Up-to (less than or equal to) $25,000 ◯ $25,001-$50,000 ◯ $50,001-$100,000 ◯ Over $100,000 ◯ Prefer not to answer
What is your job function within the dental office?	◯ Dentist ◯ Hygienist ◯ Dental Assistant ◯ Dental Care Coordinator ◯ Lab Technician ◯ Receptionist ◯ Biller or Financial Counselor ◯ Other (Check one which best describes your job function)
Do you own the dental practice/clinic or are you an employee (associate) of the dental practice/clinic	◯ Practice/Clinic Owner ◯ Associate

PPE AND OTHER MITIGATION PRACTICES

During the past 30 days, how often did YOU use the following Personal Protective Equipment (PPE) while performing/assisting with aerosol-generating dental procedures?

	Never	Rarely	Sometimes	Often	Always	Not applicable
a. Surgical mask	◯	◯	◯	◯	◯	◯
b. Plastic face shield	◯	◯	◯	◯	◯	◯
c. KN95 respirator	◯	◯	◯	◯	◯	◯
d. N95 respirator	◯	◯	◯	◯	◯	◯
e. Surgical gowns	◯	◯	◯	◯	◯	◯
f. Surgical cap	◯	◯	◯	◯	◯	◯
g. Gloves	◯	◯	◯	◯	◯	◯
h. Shoe coverings	◯	◯	◯	◯	◯	◯
i. Safety glasses with side shields (with or without magnification)	◯	◯	◯	◯	◯	◯
j. Eye goggles (protective eyewear that sits snugly against the face, often with suction, that is secured with a strap that goes around the back of the head)	◯	◯	◯	◯	◯	◯
k. Other (specify in the notes)	◯	◯	◯	◯	◯	◯

Where were you fit tested?

- ◯ At my place of employment - (click this answer if you are an employee or volunteer at a hospital, dental school, hygiene program or community health clinic and were fit tested at these locations)
- ◯ Local hospital (choose this option if you were fit tested at a hospital and you are NOT an employee or volunteer at that hospital)
- ◯ Dental School or Dental Hygiene Program (click this answer if you were fit tested at a dental school or dental hygiene program and are NOT an employee or volunteer at that school/program)
- ◯ Community Health Center (click this option if you were fit tested at a community health center and are NOT an employee or volunteer at that center)
- ◯ Private N95 fit testing service arranged by your dental office
- ◯ Service provided by the dental association
- ◯ I wasn't fit tested
- ◯ Other - please specify in notes)

What environmental controls are currently being used in your office?

	Yes	No	Not Sure
a. Social distancing (limiting patients in the office at one time)	◯	◯	◯
b. HEPA air filtration	◯	◯	◯
c. Ultraviolet light	◯	◯	◯
d. Surface disinfection	◯	◯	◯
e. Hand sanitizer	◯	◯	◯
f. 6 Foot Floor markings	◯	◯	◯
g. Block off or removing chairs for social distancing	◯	◯	◯
h. Plexiglass barriers	◯	◯	◯
i. Additional suction units	◯	◯	◯
j. Designated doors for entry and exit	◯	◯	◯
k. Directional markers for traffic flow	◯	◯	◯
l. Other (specify in notes)	◯	◯	◯

What work practice controls are currently being used in your office?

	Yes	No	Not sure
a. Patients must call practice to announce arrival	◯	◯	◯
b. Patients must wait outside the office	◯	◯	◯

c. Patients must don face covering during office entry and exit	○	○	○
d. Patients must wash hands upon entering the operatory	○	○	○
e. Patients must rinse with oral antiseptic prior to treatment	○	○	○
f. Other (specify in notes)	○	○	○

IMPORTANCE

During the height of the pandemic, how important did you think it was for PATIENTS to ...

	Extremely Important	Important	Not Important or Unimportant	Unimportant	Very Unimportant
a. be triaged for COVID-19 symptoms PRIOR (i.e.. the night before) to their office visit?	○	○	○	○	○
b. be triaged for COVID-19 symptoms UPON ENTERING the office?	○	○	○	○	○
c. have their temperature taken upon entering the office?	○	○	○	○	○
d. have pulse-oximeter reading taken upon entering the office?	○	○	○	○	○
e. have their taste and/or smell tested upon entering the office?	○	○	○	○	○
f. be tested for COVID-19 PRIOR to receiving dental treatment?	○	○	○	○	○
g. wait outside of the office?	○	○	○	○	○
h. be vaccinated against COVID-19?	○	○	○	○	○

How important do you think it is NOW for PATIENTS to ...

	Extremely Important	Important	Neither Important or Unimportant	Very Unimportant
a. be triaged for COVID-19 symptoms PRIOR (i.e., the night before) to their office visit?	○	○	○	○
b. be triaged for COVID-19 symptoms UPON ENTERING the office?	○	○	○	○
c. having their temperature taken upon entering the office?	○	○	○	○

d. have pulse-oximeter reading taken upon entering the office?	○	○	○	○
e. have their smell and/or taste tested upon entering the office?	○	○	○	○
f. be tested for COVID-19 PIOR to receiving dental treatment?	○	○	○	○
g. wait outside of the office?	○	○	○	○
h. be vaccinated against COVID-19?	○	○	○	○

During the height of the pandemic, how important do you think it was for CO-WORKERS to ...

	Extremely Important	Important	Neither Important nor Unimportant	Unimportant	Very Unimportant
a. be triaged for COVID-19 symptoms each morning upon entering the office?	○	○	○	○	○
b. have their temperature taken each morning upon entering the office?	○	○	○	○	○
c. have their pulse-oximeter reading taken each morning upon entering the office?	○	○	○	○	○
d. have their smell and/or taste tested each morning upon entering the office.	○	○	○	○	○
e. be tested regularly for COVID-19?	○	○	○	○	○
f. be vaccinated against COVID-19?	○	○	○	○	○

How important do you think it is NOW for CO-WORKERS to ...

	Extremely Important	Important	Neither Important nor Unimportant	Unimportant	Very Unimportant
a. be triaged for COVID-19 symptoms each morning upon entering the office?	○	○	○	○	○
b. have their temperature taken each morning upon entering the office?	○	○	○	○	○
c. have their pulse-oximeter reading taken each morning upon entering the office?	○	○	○	○	○

d. have their smell and/or taste tested each morning upon entering the office?	○	○	○	○	○
e. be tested regularly (i.e., once a week) for COVID-19?	○	○	○	○	○
f. be vaccinated against COVID-19?	○	○	○	○	○

SAFETY

Indicate if you strongly agree, agree, disagree or strongly disagree with each of the following statements.

	Strongly Agree	Agree	Disagree	Strongly Disagree
a. New co-workers quickly learn that they are expected to follow good safety practices.	○	○	○	○
b. There are no significant compromises or shortcuts taken when worker safety is at stake.	○	○	○	○
c. In my dental office, we work together to ensure the safest possible working conditions.	○	○	○	○
d. Office personnel are told when they do not follow good safety practices.	○	○	○	○
e. The safety of co-workers is a big priority for the practice where I work.	○	○	○	○
f. I feel free to report safety violations where I work.	○	○	○	○
f. I encourage reporting of safety violations.	○	○	○	○

Indicate how safe you feel with the COVID-19 precautions used in your dental office.

By using the slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as one can possibly be" and 100 equals "as safe as one can possibly be".

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly be

(Place a mark on the scale above)

Indicate how safe you think you would feel if all workers in your office were tested on a regular basis (i.e., once per week) AND all patients were tested prior to their appointment for COVID-19.

By using the slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as one can possibly be" and 100 equals "as safe as one can possibly be" by using the slider.

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly be

(Place a mark on the scale above)

Indicate how safe you think you would feel if all patients, but not dental care workers, were tested for COVID-19 prior to receiving dental treatment.

By using the slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as one can possibly be" and 100 equals "as safe as one can possibly be" by using the slider.

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly be

(Place a mark on the scale above)

Indicate how safe you think you would feel in your office if all workers, but not patients, were testing on a regular basis (i.e., once per week) for COVID-19.

By using the slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as one can possibly be" and 100 equals "as safe as one can possibly be" by using the slider.

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly be

(Place a mark on the scale above)

Would you refer a family or friend to this dental clinic or office?

- ◯ Definitely Refer
- ◯ Probably Refer
- ◯ Not Sure
- ◯ Probably Not Refer
- ◯ Definitely Not Refer

DENTISTS PERFORMING COVID-19 TESTS

Do you think dentists should be able to order and perform COVID-19 Tests on

	Yes	Undecided	No
a. their patients?	◯	◯	◯
b. their co-workers?	◯	◯	◯
c. themselves?	◯	◯	◯
d. the public at large?	◯	◯	◯

Would you perform COVID-19 testing on:

	Yes	Undecided	No
a. your patients?	○	○	○
b. your co-workers?	○	○	○
c. yourself?	○	○	○
d. the public at large?	○	○	○

COVID-19 TEST PREFERENCES

If you were required to take a COVID-19 test, rank in order of preference the type of specimen you would want to provide?

(Note: For this question you can only select 1 choice per VERTICAL column)

	1 = Most Desirable	2	3	4	5	6= Least Desirable
a. Blood sample via venipuncture (needle)	○	○	○	○	○	○
b. Drop of blood via finger prick	○	○	○	○	○	○
c. Saliva	○	○	○	○	○	○
d. Nasal Swab (q-tip inside the tip of the nose)	○	○	○	○	○	○
e. Nasopharyngeal (Q-tip inserted all the way to the back of the nose)	○	○	○	○	○	○
f. Tongue epithelial Cells (light scraping or brushing of tongue)	○	○	○	○	○	○

Rank order the type of COVID-19 test you would prefer to use in the office.

(Note: For this question you can only provide 1 choice per VERTICAL column)

	Most Preferable	Preferable	Not Very Preferable	Least Preferable
a. A test which requires the patient to go to a COMMERCIAL LAB or testing center. You would receive results in 2-3 days.	○	○	○	○
b. A test which requires a patient to come to YOUR OFFICE TO COLLECT THE SPECIMEN (saliva, nasal swab or drop of blood). You would send the sample to the lab and results would be available in 2-3 days.	○	○	○	○

c. A test which patient can do at HOME. The test kit could be either picked up at your office or mailed to your patient. Your patient would mail the specimen (i.e. saliva, nasal swab) to a lab for processing and result available in 2-3 days hours.	○	○	○	○
d. A POINT OF CARE test which you would perform in your office. Results would be available in 15-20 minutes.	○	○	○	○

Address for Mailing Compensation and State Reporting Requirements

Street Address 1

_____

Street Address 2

_____

City

_____

State (two letter abbreviation)

_____

County

_____

Age

_____

Email Address

_____

Best Phone Number

_____

NOTES AND COMMENTS

Notes/Comments

_____

Start of Study Triage Case Report

Subject Study ID

_____

Subject: [consent_arm_1][name_last], [consent_arm_1][name-first]

	Yes	No	Not Sure
a. Fever or chills	○	○	○
b. Cough	○	○	○
c. Shortness of Breath or Difficulty Breathing	○	○	○
d. Fatigue	○	○	○
e. Muscle or Body Aches	○	○	○
f. Headache	○	○	○
g. Loss of Taste	○	○	○
h. Loss of Smell	○	○	○
i. Sore Throat	○	○	○
j. Congestion or Runny Nose	○	○	○
k. Nausea or Vomiting	○	○	○
l. Diarrhea	○	○	○

Temperature and Pulse Oximeter Readings

Participant's Temperature

_____

Participant's pulse oximeter reading?

_____

Notes or Comments

Notes or Comments

_____

Start of Study Test Order

Subject Study ID	_____
Testing Date	_____
Test Type	☐ PCR Viral (Saliva) ☐ PCR Viral (Nasal) ☐ PCR Viral (Tongue) ☐ POC Antigen (BD Veritor - Nasal) ☐ ELISA Antibody (Fingerprick)
Saliva Tube Bar Code	_____
Nasal Kit Bar Code	_____
Tongue Tube Bar Code	_____
Mitra Cartridge Bar Code	_____
POC Bar Code (on BD Veritor System SARS-CoV-2 Device Package)	_____
Notes and Comments	_____

Start of Study PCR and Antibody Test Results

Subject Study ID

_____

Saliva PCR Viral Test Results

Saliva Collection Kit Bar Code

_____

Saliva Specimen Collection Date

_____

Saliva PCR Test Result Date

_____

Saliva PCR Result

◯ Positive
◯ Negative
◯ Inconclusive

Saliva PCR Cycles

_____

Initials of Individual Entering Saliva PCR Results

_____

Tongue Cell PCR Viral Test

Tongue Cell Collection Kit Bar Code

_____

Tongue Cell Collection Date

_____

Tongue PCR Test Result Date

_____

Tongue PCR Result

◯ Positive
◯ Negative
◯ Inconclusive

Tongue PCR Cycles

_____

Initials of Individual Entering Results

_____

Blood Droplet ELISA Antibody Test Results

Blood Droplet Collection Kit Bar Code

_____

Blood Droplet Specimen Collection Date

_____

ELISA Antibody Result Date

_____

ELISA Antibody Result - IgG

_____

ELISA Antibody Result - IgM

_____

ELISA Antibody Result - IgA

_____

Initials of Individual Entering Results

_____

Notes and Comments

Notes and Comments

_____

POC ONLY Start of Study POC Antigen Test Results

Subject Study ID _____

Nasal Point of Care Test Date _____

Nasal Point of Care Test Results
◯ Positive
◯ Not Sure
◯ Negative

POC Test Results Reporting

The State of NJ requires that a test report be filed. To file the report you must:
1) Log onto the state reporting sytem
2) ?????
3) Select enter new test result
4) Enter the information below

Patient Name: [consent_arm_1][name_last], [consent_arm_1][name_first]
Patient Address: [pilot_arm_1][street1], [pilot_arm_1][street2], [pilot_arm_1][city], [pilot_arm_1][state], [pilot_arm_1][zipcode]
Patient Phone Number: [pilot_arm_1][phone]
Patient Date of Birth: [pilot_arm_1][birthdate]
Dentist Address:
Dentist Phone Number:
Test Performed: (use harmonized LOINC codes provided by CDC)
Device Identifier:
Test Result: (use appropriate LOINC and SNOMED codes)
Test Result Date:[pilot_arm_1][s_nasalpoc_results]
Accession number/Specimen ID:
Patient Age:
Patient Race: [pilot_arm_1][race]
Patient Ethnicity: [pilot_arm_1][ethncity]
Patient Sex: [pilot_arm_1][gender]
Patient Residence Zip Code: [pilot_arm_1][zipcode]
Patient Residence County
Ordering Provider Name and NPI:
Ordering Provider Zip Code:
Performing Facility Name and/or CLIA Number:
Performing Facility Zip Code
Specimen Source: (Use appropriate LOINC, SNOMED-CT, or SPM4 codes, or equivalent detailed alternative codes)
Date Test Ordered:
Date Specimen Collected: [pilot_arm_1][s_nasalpoc_sdate]

5) Save the record

Initials of Individual Reporting Test By initialing I am attesting that test results were reported to the NJ Department of Health	_____
Date Test Results Was Reported to the Department of Health	_____
Notes or Comments	_____

Mid Study Triage Case Report

Subject Study ID

_____

Do you have any of the following symptoms?

	Yes	No	Not Sure
a. Fever or chills	◯	◯	◯
b. Cough	◯	◯	◯
c. Shortness of Breath or Difficulty Breathing	◯	◯	◯
d. Fatigue	◯	◯	◯
e. Muscle or Body Aches	◯	◯	◯
f. Headache	◯	◯	◯
g. Loss of Taste	◯	◯	◯
h. Loss of Smell	◯	◯	◯
i. Sore Throat	◯	◯	◯
j. Congestion or Runny Nose	◯	◯	◯
k. Nausea or Vomiting	◯	◯	◯
l. Diarrhea	◯	◯	◯

Temperature and Pulse Oximeter Readings

Participant's temperature?

_____

Participant's Pulse Oximeter Reading

_____

Notes or Comments

Initial of Individual Performing Triage

Notes or Comments

_____

Mid Study Test Order

Subject Study ID _____

Saliva Collection Kit Bar Code _____

Tongue Cell Collection Kit Bar Code _____

Nasal Point of Care Kit Bar Code _____

Blood Droplet Collection Kit Bar Code _____

Initials of Individual Packing Subject Kit _____

Collection Kit Packing Date _____

Notes and Comments _____

LAB ONLY Mid Study PCR Test Results

Subject Study ID

_____

Saliva PCR Viral Test Results

Saliva Collection Kit Bar Code

_____

Saliva Specimen Collection Date

_____

Saliva PCR Test Result Date

_____

Saliva PCR Result

◯ Positive
◯ Negative
◯ Inconclusive

Saliva PCR Cycles

_____

Initials of Individual Entering Saliva PCR Test Results

_____

Tongue PCR Test Results

Tongue Cell Collection Kit Bar Code

_____

Tongue Cell Collection Date

_____

Tongue PCR Test Result Date

_____

Tongue PCR Result

◯ Positive
◯ Negative
◯ Inconclusive

Tongue PCR Cycles

_____

Initials of Individual Entering Tongue PCR Test Results

_____

ELISA Antibody Test Results

Blood Droplet Collection Kit Bar Code

_____

Blood Droplet Collection Date

_____

ELISA Antibody Result Date

_____

ELISA Antibody Result - IgG

_____

ELISA Antibody Result - IgM

_____

ELISA Antibody Result - IgA

_____

Initials of Individual Recording Antibody Results

_____

Notes and Comments

Notes and Comments

_____

POC ONLY Mid Study POC Antigen Test Results

Subject Study ID _____

POC Test Restuls

Nasal Point of Care Test Date _____

Nasal Point of Care Test Results
◯ Positive
◯ Not Sure
◯ Negative

POC Test Results Reporting

The State of NJ requires that a test report be filed. To file the report you must:
1) Log onto the state reporting sytem
2) ?????
3) Select enter new test result
4) Enter the information below

Patient Name: [consent_arm_1][name_last], [consent_arm_1][name_first]
Patient Address:
Patient Phone Number:
Patient Date of Birth:
Dentist Address:
Dentist Phone Number:
Test Performed: (use harmonized LOINC codes provided by CDC)
Device Identifier:
Test Result: (use appropriate LOINC and SNOMED codes)
Test Result Date:
Accession number/Specimen ID:
Patient Age:
Patient Race:
Patient Ethnicity:
Patient Sex:
Patient Residence Zip Code:
Patient Residence County
Ordering Provider Name and NPI:
Ordering Provider Zip Code:
Performing Facility Name and/or CLIA Number:
Performing Facility Zip Code
Specimen Source: (Use appropriate LOINC, SNOMED-CT, or SPM4 codes, or equivalent detailed alternative codes)
Date Test Ordered:
Date Specimen Collected:

5) Save the record

Initials of Individual Reporting Test By initialing I am attesting that test results were reported to the NJ Department of Health	_____
Date Test Results Was Reported to the Department of Health	_____
Notes or Comments	_____

End of Study Triage Case Report

Subject Study ID _____

Do you have any of the following symptoms?

	Yes	No	Not Sure
a. Fever or chills	○	○	○
b. Cough	○	○	○
c. Shortness of Breath or Difficulty Breathing	○	○	○
d. Fatigue	○	○	○
e. Muscle or Body Aches	○	○	○
f. Headache	○	○	○
g. Loss of Taste	○	○	○
h. Loss of Smell	○	○	○
i. Sore Throat	○	○	○
j. Congestion or Runny Nose	○	○	○
k. Nausea or Vomiting	○	○	○
l. Diarrhea	○	○	○

Temperature and Pulse Oximeter Readings

Participant's Temperature _____

Participant's pulse oximeter reading? _____

Notes or Comments

Notes or Comments _____

End of Study Test Order

Subject Study ID _____

Saliva Collection Kit Bar Code _____

Tongue Cell Collection Kt Bar Code _____

Blood Droplet Collection Kit Bar Code _____

Initials of Individual Packing Specimen Kits _____

Specimen Collection Kit Packing Date _____

Notes and Comments _____

End of Study PCR and Antibody Test Results

Subject Study ID

_____

Saliva Tube Bar Code

_____

Nasal Kit Bar Code

_____

Tongue Tube Bar Code

_____

Mitra Cartridge Bar Code

_____

Nasal Point-of-Care Antigen Test Results

Nasal POC Antigen Test Result Date

_____

Nasal POC Antigen Test Result

◯ Negative
◯ Positive
◯ Inconclusive
◯ Invalid Sample or Error in Test
◯ Other (specify in notes)

Saliva PCR Viral Test Results

Saliva PCR Test Result Date

_____

Saliva PCR Result

◯ Positive
◯ Negative
◯ Inconclusive

Saliva PCR Cycles

_____

Tongue PCR Viral Test Results

Tongue PCR Viral Test Result Date

_____

Tongue PCR Viral Result

◯ Positive
◯ Negative
◯ Inconclusive

Tongue PCR Cycles

_____

Blood ELISA Antibody Test Results

ELISA Antibody Result Date

_____

Blood Antibody Result - IgG

_____

Blood Antibody Result - IgM

_____

Blood Antibody Result - IgA

_____

Notes and Comments

Notes and Comments

_____

POC ONLY End of Study POC Antigen Test Results

Subject Study ID _____

Nasal Point of Care Test Date _____

Nasal Point of Care Test Results
- ◯ Positive
- ◯ Not Sure
- ◯ Negative

POC Test Results Reporting

The State of NJ requires that a test report be filed. To file the report you must:
1) Log onto the state reporting sytem
2) ?????
3) Select enter new test result
4) Enter the information below

Patient Name: [consent_arm_1][name_last], [consent_arm_1][name_first]
Patient Address:
Patient Phone Number:
Patient Date of Birth:
Dentist Address:
Dentist Phone Number:
Test Performed: (use harmonized LOINC codes provided by CDC)
Device Identifier:
Test Result: (use appropriate LOINC and SNOMED codes)
Test Result Date:
Accession number/Specimen ID:
Patient Age:
Patient Race:
Patient Ethnicity:
Patient Sex:
Patient Residence Zip Code:
Patient Residence County
Ordering Provider Name and NPI:
Ordering Provider Zip Code:
Performing Facility Name and/or CLIA Number:
Performing Facility Zip Code
Specimen Source: (Use appropriate LOINC, SNOMED-CT, or SPM4 codes, or equivalent detailed alternative codes)
Date Test Ordered:
Date Specimen Collected:

5) Save the record

Initials of Individual Reporting Test By initialing I am attesting that test results were reported to the NJ Department of Health	_____
Date Test Results Was Reported to the Department of Health	_____
Notes or Comments	_____

DHCW End of Study Survey

Subject Study ID _____

Subject Name: [consent_arm_1][consent_subj_name]

Date of End of Study Survey _____

CONCERN

How concerned are you with:

	Not Concerned at All	Mild Concern	Moderate Concern	Severe Concern
a. getting sick from patients?	◯	◯	◯	◯
b. getting sick from your office co-workers?	◯	◯	◯	◯

IMPORTANCE

How important do you think it is NOW for PATIENTS to ...

	Extremely Important	Important	Not Important or Unimportant	Unimportant	Very Unimportant
a. be triaged for COVID-19 symptoms prior to their office visit?	◯	◯	◯	◯	◯
b. be triaged for COVID-19 symptoms upon entering the office?	◯	◯	◯	◯	◯
c. have their temperature taken upon entering the office?	◯	◯	◯	◯	◯
d. have pulse-oximeter reading taken upon entering the office?	◯	◯	◯	◯	◯
e. have their taste and/or smell tested upon entering the office?	◯	◯	◯	◯	◯
f. be tested for COVID-19 prior to receiving dental treatment?	◯	◯	◯	◯	◯
g. wait outside of the office?	◯	◯	◯	◯	◯
h. be vaccinated against COVID-19?	◯	◯	◯	◯	◯

How important do you think it is NOW for CO-WORKERS to:	Extremely Important	Important	Neither Important nor Unimportant	Unimportant	Very Important
a. be triaged for COVID-19 symptoms each morning upon entering the office?	○	○	○	○	○
b. have their temperature taken each morning upon entering the office?	○	○	○	○	○
c. have their pulse-oximeter reading taken each morning upon entering the office?	○	○	○	○	○
d. have their taste and/or smell tested each morning upon entering the office?	○	○	○	○	○
e. be tested regularly (i.e., once per week) for COVID-19?	○	○	○	○	○
f. be vaccinated against COVID-19?	○	○	○	○	○

SAFETY

Indicate whether you strongly agree, agree, disagree or strongly disagree with each statement.

	Strongly Agree	Agree	Disagree	Strongly Disagree
a. New co-workers quickly learn that they are expected to follow good safety practices.	○	○	○	○
b. There are no significant compromises or shortcuts taken when worker safety is at stake.	○	○	○	○
c. In my dental office, we work together to ensure the safest possible working conditions.	○	○	○	○
d. Office personnel are told when they do not follow good safety practices.	○	○	○	○
e. The safety of co-workers is a big priority for the practice where I work.	○	○	○	○
f. I feel free to report safety violations where I work.	○	○	○	○

f. I encourage reporting of safety violations.	◯	◯	◯	◯

Indicate how safe you feel with the COVID-19 precautions used in your dental office.

By using the slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as once can possibly be" and 100 equals "as safe as one can possibly be".

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly be

(Place a mark on the scale above)

Indicate how safe you think you would feel if all workers were tested in your office on a regular basis (i.e., once per week) AND all patients were tested prior to their appointments for COVID-19.

By using the slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as one can possibly be" and 100 equals "as safe as one can possibly be".

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly be

(Place a mark on the scale above)

Indicate how safe you think you would feel in your office if all workers, but not patients, were tested on a regular basis (i.e., once per week) for COVID-19.

By using the slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as one can possibly be" and 100 equals "as safe as one can possibly be".

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly be

(Place a mark on the scale above)

Indicate how safe you think you would feel if all patients, but not dental care workers, were tested for COVID-19 prior to receiving dental treatment.

By using the slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as one can possible be" and 100 equals "as safe as one can possibly be."

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly be

(Place a mark on the scale above)

Would you refer a family or friend to this dental clinic or office?

- ◯ Definitely refer
- ◯ Probably refer
- ◯ Not sure
- ◯ Probably not refer
- ◯ Definitely not refer

COVID-19 TEST PREFERENCES

If you were required to take a COVID-19 test, rank in order of preference the type of specimen you would wnat to provide.
(Note: For this question you can only select 1 choice per VERTICAL column)

	1 = Most Desirable	2	3	4	5	6 = Least Desirable
a. Blood sample via vent-unction (needle)	○	○	○	○	○	○
b. Drop of blood via finger prick	○	○	○	○	○	○
c. Saliva	○	○	○	○	○	○
d. Nasal Swab (q-tip inside the tip of the nose)	○	○	○	○	○	○
e. Nasal Pharingeal (Q-tip inserted all the way to the back of the nose)	○	○	○	○	○	○
f. Tongue or Cheek Cells (light scraping of tongue and cheek tissue)	○	○	○	○	○	○

COIVD-19 TESTING ACCURACY

No test is perfect. The following questions ask about your tolerance for these imperfections.

In order for you to consider COVID-19 testing worthwhile, what is the maximum percentage of false positives you would find acceptable?

A false positive is when the COVID-19 test is positive but the individual tested does not have COVID-19. For workers this means they may be out of work for a couple of days until another test result is obtained and for patients this means that their appointment would be canceled and rescheduled.

By using the slider or entering the percentage in the box, indicate the maximum false positive percentile that you feel would be acceptable. Zero percent (0%) means that you would not be willing to accept any error and 50% means that out of 100 patients, 50 patient test results would be wrong.

The SMALLER the number, the less error you are willing to accept.

0% 50% 100%

(Place a mark on the scale above)

In order for you to consider COVID-19 testing worthwhile, what is the maximum percentage of false negatives you would accept?

A false negative is when the COVID-19 test is negative but the individual tested has COVID-19. For workers this means they may come to work not knowing they have COVID-19. For patients, this means that dental health care workers would be exposed to COVID-19 as a results of treating a COVID-19 positive patient, though workers would not know the patient is COVID-19 positive.

By using the slider or entering the number in the box, indicate the maximum false negative percentile that you feel would be acceptable. Zero percent (0%) means that you would not be willing to accept any error and 50% means that out of 100 patients, 50 patient test results would be wrong.

The SMALLER the number, the less error you are willing to accept.

0% 50% 100%

(Place a mark on the scale above)

In order for you to consider COVID-19 testing worthwhile, what is the lowest SENSITIVITY percentage you would accept?

Sensitivity is the percentage of true positive patients who tests positive.

By using the slider or entering the number in the box, indicate the minimum sensitivity percentile that you feel would be acceptable. 100 percent (100%) means that you would not be willing to accept any error and 50% percent means that 1/2 of patient test results would be wrong.

The LARGER the number, the less error you are willing to accept.

0% 50% 100%

(Place a mark on the scale above)

In order for you to consider COVID-19 testing worthwhile, what is the lowest SPECIFICITY percentage you would accept?

Specificity is the percentage of true negative patientswho test negative.

By using the slider or entering the number in the box, indicate the minimum specificity percentile that you feel would be acceptable. 100 percent (100%) means that you would not be willing to accept any error and 50% percent means that 1/2 of patient test results could be wrong.

The LARGER the number, the less error you are willing to accept.

0% 50% 100%

(Place a mark on the scale above)

COST OF COVID-19 TESTING

At what price-point do you believe regular (i.e., once a week) dental healthcare worker COVID-19 testing would be viable, assuming that medical insurance will not provide reimbursement for the tests?

By using the slider, indicate the maximum price you believe a dental office would be willing to pay for a dental healthcare worker's COVID-19 Testing?

$0 $50 $100

(Place a mark on the scale above)

At what price-point do you believe patient COVID-19 testing prior to a dental appointment is viable, assuming medical and dental insurance plans will NOT provide reimbursement.

By using the slider, indicate the maximum price you believe a dental office would be willing to pay for a COVID-19 test. Assume the cost can be passed on to the patient either through directly charging the patient for the test or by slightly increases your fees across all procedures.

$0 $50 $100

(Place a mark on the scale above)

Rank order the type of COVID-19 test you would prefer to use in your office.

(Note: For this question you can only provide 1 choice per VERTICAL column.)

	Most Preferable	Preferable	Not Very Preferable	Least Preferable
a. A test which requires the patient to go to a COMMERCIAL LAB or testing center. You would receive results in 2-3 days.	◯	◯	◯	◯
b. A test which requires a patient to come to YOUR OFFICE TO COLLECT THE SPECIMEN (saliva, nasal swab or drop of blood). You would send the sample to the lab and results would be available in 2-3 days.	◯	◯	◯	◯
c. A test which patients can do at HOME. The test kit could be either picked up at your office or mailed to your patient. Your patient would mail the specimen (i.e. saliva, nasal swab, drop of blood) to a lab for processing and results available in 2-3 days.	◯	◯	◯	◯

d. A POINT-OF-CARE test which you would perform in your office. Results would be available in 15-20 minutes.	○	○	○	○

VACCINATIONS

	Yes	Undecided	No
Should dentists be able to give the COVID-19 vaccination?	○	○	○
Would you give the COVID-19 vaccination to your patients?	○	○	○
Would you be willing to be part of the public health system and provide the COVID-19 vaccination to individuals who are not patients of record in your office?	○	○	○

COVID-19 SYMPTOM REPORTING

How likely are you to report a COVID-19 symptom as part of an office triage protocol if you believe the symptom is...

	Very Likely	Likely	Not Sure	unlikely	Very Unlikely	My Office Does Not Triage Employees for COVID-19 Symptoms
NOT related to COVID-19?	○	○	○	○	○	○
Related to COVID-19?	○	○	○	○	○	○

Do you currently have...

	yes	No	Prefer not to answer
a. Hay fever (sneezing)?	○	○	○
b. Chronic pulmonary disease which results in your coughing?	○	○	○
c. Soreness of aching muscles due to exercise or recent activities?	○	○	○
d. Chronic GI issues which result in stomach upset or diarrhea?	○	○	○
e. Sore throat due to a cold?	○	○	○

f. Fever due to the flu or other infection?	◯	◯	◯

What is the most important factor that influences your decision not to report?

◯ Potential loss of income
◯ Potential disruption of personal and family life
◯ Stigma of COVID-19 infection
◯ Fear of isolation
◯ Other

Other

_____

NOTES AND COMMENTS

Notes/Comments

_____

Patient Pre-Visit Survey

Please complete the survey below.

Thank you!

Study Name: PREDICT- Pragmatic Return to Effective Dental Infection Control through Triage and Testing

Subject Name: [consent_arm_1][consent_subj_name]

Date of Pre-Visit Survey _____

COVID-19 EXPOSURE AND VACCINATION

Have you every been diagnosed with COVID-19 by your doctor or by a COVID-19 test?
- ◯ No
- ◯ Not Sure
- ◯ Yes
- ◯ Prefer Not to Answer

Has anyone you live with ever been diagnosed with COVID-19 by your doctor or by a COVID-19 test?
- ◯ No
- ◯ Not Sure
- ◯ Yes
- ◯ Prefer Not to Answer

Have you had the COVID-19 Vaccine?
- ◯ No
- ◯ Not Sure
- ◯ Yes
- ◯ Prefer Not to Answer

Do you plan on getting the COVID-19 vaccine?
- ◯ No
- ◯ Not Sure
- ◯ Yes
- ◯ Prefer not to answer

CONCERNS AND SAFETY

Since the beginning of the COVID-19 pandemic, have you ever delayed making an appointment for your dental care because of the COVID-19 pandemic?
- ◯ Yes
- ◯ No

Indicate how safe you feel seeking dental care now.

By using the slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as one can possibly be" and 100 equals "as safe as one can possibly be."

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly be

(Place a mark on the scale above)

Indicate how safe you think you would feel seeking dental care if all dental workers were regularly tested (i.e., once per week) for COVID-19 AND all patients were tested prior to their dental appointments.

By using the slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as one can possibly be" and 100 equals "as safe as one can possibly be."

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly be

(Place a mark on the scale above)

Indicate how safe you think you would feel seeking dental care if all dental workers, but not patients, were regularly tested (i.e., once per week) for COVID-19.

By using the slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as one can possibly be" and 100 equals "as safe as one can possibly be."

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly be

(Place a mark on the scale above)

Indicate how safe you think you would feel seeking dental care if all patients, but not dental care workers, were tested prior to their dental appointments.

By using the slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as one can possibly be" and 100 equals "as safe as one can possibly be."

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly be

(Place a mark on the scale above)

How concerned are you with:

	Not Concerned at All	Mild concern	Moderate Concern	Severe Concern
a. Getting sick from other patients?	◯	◯	◯	◯
b. Getting sick from dental clinic staff?	◯	◯	◯	◯
c. Cleanliness of facilities?	◯	◯	◯	◯
d. Availability of proper protective equipment?	◯	◯	◯	◯

How important do you think it is to:

	Extremely Important. 1	2	3	4	Very Unimportant. 5

a. screen DENTISTS and OFFCIE STAFF for COVID-19 symptoms upon entering the office each day?	○	○	○	○	○
b. regularly test the DENTISTS and OFFICE STAFF for COVID-19 virus	○	○	○	○	○
c. have all DENTISTS and OFFICE STAFF vaccinated against COVID-19?	○	○	○	○	○
d. screen PATIENTS for COVID-19 symptoms by phone the NIGHT BEFORE their dental visit?	○	○	○	○	○
e. screen PATIENTS for COVID-19 symptoms upon entering the dental office?	○	○	○	○	○
f. take patient temperatures upon entering the dental office	○	○	○	○	○
g. take patient blood oxygen levels upon entering the dental offic	○	○	○	○	○
h. test patient taste and smell upon entering the dental office?	○	○	○	○	○
i. test patients for COVID-19 prior to receiving dental treatment	○	○	○	○	○
j. socially distance patients while in the office (i.e. have patients sit 6 feet apart in the waiting room)?	○	○	○	○	○
k. have patients wait outside of the dental office	○	○	○	○	○
l. provide patients with face masks?	○	○	○	○	○
m. have other patients seen in the office vaccinated against COVID-19?	○	○	○	○	○

Demographics

What is your sex?	◯ Male ◯ Female ◯ Other ◯ Prefer not to answer
What is your date of birth?	_____
What is your age?	_____
Are you of Hispanic or Latino origin?	◯ Yes ◯ No ◯ Prefer not to answer
What racial categories best describe you? (check all that apply)	☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African-American ☐ White or Caucasian ☐ Prefer not to answer
Indicate your highest level of formal education:	◯ Less than high school diploma ◯ High school diploma or GED ◯ Some college/Associate degree ◯ Bachelor's degree ◯ Graduate degree ◯ Prefer not to answer
How would you describe the community to live in?	◯ Urban ◯ Suburban ◯ Rural ◯ Prefer not to answer
What is your family's current annual household income from all sources?	◯ Up-to (less than or equal to) $25,000 ◯ $25,001-$50,000 ◯ $50,001-$100,000 ◯ Over $100,000 ◯ Prefer not to answer
Including you, how many people live in your household?	_____
What type of dental insurance do you have? (Check all that apply)	☐ No dental insurance ☐ Private insurance (e.g. employer sponsored, commercial HMO, etc) ☐ Public/government insurance (Medicaid, military or veterans benefit, etc.) ☐ Other ☐ I don't know ☐ Prefer not to answer
Do you work in a healthcare related field?	◯ No ◯ Yes ◯ Prefer not to answer

Address for Mailing Compensation

This section needs to be completed if you would like compensation for participating in this research project.)

Street Address 1

Street Address 2

City

County

State (two letter abbreviation)

Zip Code

e-Mail Address

Best Phone Number

Notes and Comments

Notes/Comments

Visit Triage Case Report

Subject Study ID

_____

Study Name: PREDICT- Pragmatic Return to Effective Dental Infection Control through Triage and Testing

Subject Name: [consent_arm_1][name_last],[consent_arm_1][name_first]

Date of Visit

_____

Do you have any of the following symptoms?

	Yes	No	Not Sure
a. Fever or chills	○	○	○
b. Cough	○	○	○
c. Shortness of breath or difficulty breathing	○	○	○
d. Fatigue	○	○	○
e. Muscle and body aches	○	○	○
f. Headache	○	○	○
g. Lost of Taste	○	○	○
h. Lost of Smell	○	○	○
i. Sore throat	○	○	○
j. Congestion or runny nose	○	○	○
k. Nausea or Vomiting	○	○	○
l. Diarrhea	○	○	○

Temperature in degrees F

_____

Blood oxygen saturation level

_____

Comments / Notes

_____

Initials of Individual Recording Triage Results

_____

I attest the triage information has been accurately recorded.

Once all fields have been completed, save this form as "unverified."

Testing Specimen Order

Subject Study ID

_____

Study Name: PREDICT- Pragmatic Return to Effective Dental Infection Control through Triage and Testing

Subject Name: [consent_arm_1][consent_subj_name]
Subject ID:[consent_arm_1][study_id]

Kit Packing Date

_____

Saliva Collection Kit Bar Code

_____

Nasal POC Kit Bar Code

_____

Notes and Comments

_____

Initials of Individual Entering Kit Codes

_____

Once all fields have been completed, save this form as "unverified."

Test Results

Subject Study ID _____

Study Name: PREDICT- Pragmatic Return to Effective Dental Infection Control through Triage and Testing

Subject Name: [consent_arm_1][name_first] [consent_arm_1][name_last]
Subject ID:[consent_arm_1][study_id]

Saliva Collection Kit Unique Bar Code _____

Nasal POC Test Kit Bar Code _____

Saliva Collection Date _____

Test Results Date _____

Saliva PCR Viral Test Results PHRI Lab
◯ Negative
◯ Positive
◯ Inconclusive
◯ Invalid Sample or Error in Test
◯ Other (specify in notes)

Nasal POC Antigen Test Results
◯ Negative
◯ Positive
◯ Inconclusive
◯ Invalid Sample or Error in Test
◯ Other (specify in notes)

Saliva PCR Cycles _____

Notes and Comments _____

Initials of Individual Entering Test Results _____

Once all fields have been completed, save this form as "unverified."

Patient End-of-Visit Survey

Subject Study ID

_____

Study Name: PREDICT- Pragmatic Return to Effective Dental Infection Control through Triage and Testing

Subject Name: [consent_arm_1][consent_subj_name]

Date of Visit

_____

SAFETY AND COMFORT

If you had a choice of going to a dental office where patients and staff are tested or going to a dental office where patients and staff are NOT tested, which office would you prefer to go to?

- ◯ It doesn't make a difference
- ◯ testing office
- ◯ non-testing office

Does taking a COVID-19 test before treatment make you feel more or less comfortable going to the dentist?

- ◯ A lot More Comfortable
- ◯ More Comfortable
- ◯ The Same
- ◯ Less Comfortable
- ◯ A Lot Less Comfortable

Indicate how safe you felt today seeking dental care.

By using teh slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as one can possibly be" and 100 equals "as safe as one can possibly be."

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly feel

(Place a mark on the scale above)

Indicate how safe you think you would feel seeking dental care if all dental workers were regularly tested (i.e., once per week) for COVID-19 AND all patients were tested prior to their dental appointments.

By using the slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as one can possibly be" and 100 equals "as safe as one can possibly be."

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly feel

(Place a mark on the scale above)

Indicate how safe you think you would feel seeking dental care if all dental office workers, but not patients, were regularly tested (i.e., once per week) for COVID-19.

By using the slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as one can possibly be" and 100 equals "as safe as one can possibly be."

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly feel

(Place a mark on the scale above)

Indicate how safe you think you would feel seeking dental care if all patients, but not dental care workers, were tested prior to their dental appointments.

By using the slider, indicate your feeling of safety on a scale from 0 to 100 where 0 equals "as unsafe as one can possibly be" and 100 equals "as safe as one can possibly be."

0 = As UNSAFE as one can possibly be

100 = As SAFE as one can possibly feel

(Place a mark on the scale above)

What personal protective equipment (PPE) did you see being used in the office?

	Yes	Unsure	No
a. Surgical face masks	○	○	○
b. KN95 or N95 masks	○	○	○
c. Plastic face Shields	○	○	○
d. Surgical gowns	○	○	○
e. Surgical caps	○	○	○
f. Gloves	○	○	○
g. Shoe coverings	○	○	○

What environmental controls did you see being used in the office?

	Yes	Unsure	No
a. Social distancing (limiting patients in the office at one time)	○	○	○
b. HEPA air filtration	○	○	○
c. Ultraviolet light	○	○	○
d. Surface disinfection	○	○	○
e. Hand sanitizer	○	○	○
f. 6 Foot Floor markings	○	○	○
g. Block off or removing chairs for social distancing	○	○	○
h. Plexiglass barriers	○	○	○
i. Additional suction units	○	○	○

j. Other (specify in notes)	○	○	○

CONCERN ABOUT DENTAL TREATMENT

As you reflect back on your visit, how Concerned were you with:

	Not Concerned at All	Mild concern	Moderate Concern	Severe Concern
a. getting sick from other patients?	○	○	○	○
b. getting sick from dental clinic staff?	○	○	○	○
c. cleanliness of facilities?	○	○	○	○
d. availability of proper protective equipment?	○	○	○	○

IMPORTANCE

As you reflect back on your visit, how important do you think it is to:

	Extremely Important 1	2	3	4	Very Unimportant 5
a. screen DENTISTS and OFFICE STAFF for COVID-19 symptoms upon entering the office each day?	○	○	○	○	○
b. regularly test DENTISTS and OFFICE STAFF for the COVID-19 virus?	○	○	○	○	○
c. have all DENTSITS and OFFICE STAFF vaccinated against COVID-19?	○	○	○	○	○
d. screen PATIENTS for COVID-19 symptoms by phone the NIGHT BEFORE their dental visit	○	○	○	○	○
e. screen PATIENTS for COVID-19 symptoms upon entering the dental office?	○	○	○	○	○
f. take patient temperatures upon entering the dental office?	○	○	○	○	○
g. take patient blood oxygenation levels upon entering the dental office?	○	○	○	○	○
h. test patient taste and smell upon entering the dental office	○	○	○	○	○

i. test patients for COVID-19 prior to receiving dental treatment?	◯	◯	◯	◯	◯
j. social distance patients while in the dental office (i.e. have patients sitting 6 feet apart) in the waiting room ?	◯	◯	◯	◯	◯
k. have patients wait outside of the dental office?	◯	◯	◯	◯	◯
l. provide patients with face masks?	◯	◯	◯	◯	◯
m. have all patients seen in the office be vaccinated against COVID-19?	◯	◯	◯	◯	◯

REPORTING COVID-19 SYMPTOMS

How likely are you to report a COVID-19 symptom to your dentist?

	Very likely	likely	Not Sure	Unlikely	Very Unlikely
a. If I believe it is NOT related to COVID-19	◯	◯	◯	◯	◯
b. If I believe it IS related to COVID-19	◯	◯	◯	◯	◯

Do you think that you will be turned away from seeing your dentist if you report a COVID symptom even if you believe you don't have COVID-19?

◯ Likely to be Turned Away
◯ Not Sure
◯ Likely Not to be Turned Away

MEDICAL HISTORY

Do you currently have:

	Yes	No	Don't Want to Answer
a. Hay fever (sneezing)	◯	◯	◯
b. Chronic pulmonary disease which results in your coughing	◯	◯	◯
c. Soreness or aching muscles due to exercise or recent activities	◯	◯	◯
e. Chronic GI issues which result in upset stomach or diarrhea	◯	◯	◯
f. Sinus or migraine headaches	◯	◯	◯
g. Sore throat due to a cold	◯	◯	◯

h. Fever due to the flu or other infection	○	○	○

ORDERING COVID-19 TESTS

	Yes	Undecided	No
Would you like for dentists to be able to order a COIVD-19 test for you?	○	○	○

COVID-19 TEST PREFERENCES

If you were required to take a COVID-19 test, rank in order of preference the type of specimen you would want to provide?
(Note: For this question you can only select 1 choice per VERTICAL column.)

	Most Desirable. 1	2	3	4	5	Lease Desirable 6
a. Blood sample via a needle placed into a vein	○	○	○	○	○	○
b. Drop of blood via finger prick	○	○	○	○	○	○
c. Saliva	○	○	○	○	○	○
d. Nasal Swab (q-tip inside the tip of the nose)	○	○	○	○	○	○
e. Nasopharyngeal (Q-tip inserted all the way to the back of the nose)	○	○	○	○	○	○
f. Tongue or Cheek Cells (light brushing of tongue and cheek tissue)	○	○	○	○	○	○

If you are required to have a COVID-19 test prior to receiving dental treatment, rank order the type of COVID-19 test you would prefer to use in the office.
(Note: For this question you can only provide 1 choice per VERTICAL column.)

	Most Preferable. 1	2	3	Lease Preferable. 4
a. A test which requires you to go to a COMMERCIAL LAB or testing center. You would receive results in 2-3 days.	○	○	○	○
b. A test which requires you to COME TO YOUR DENTIST'S OFFICE to provide the biological sample. Results would be available in 2-3 days.	○	○	○	○

c. A test which you can do at HOME. A test kit would be mailed to you. You would spit into a tube and then mail the tube to a lab for processing. Results would be available in 2-3 days.	○	○	○	○
d. A POINT OF CARE test which can be performed in your dental office right before your visit. Results would be available in 15-20 minutes.	○	○	○	○

COST

Assuming that you medical insurance company will NOT reimburse you, how much would you be willing to pay for a COVID-19 test prior to a dental appointment.

By using the slider, indicate the maximum price you believe a dental office would be willing to pay for a COVID-19 test.

$0 $50 $100

(Place a mark on the scale above)

VACCINATIONS

Would you be interested in receiving your annual flu vaccination from your dentist?

- ☐ No - I am not interested in getting a flu vaccine at all
- ☐ No - I prefer getting my flu vaccination from my physician or pharmacist
- ☐ Not sure
- ☐ Yes - I would be interested in being vaccinated by my dentist

If COVID-19 vaccinations were required annually, would you be interested in receiving your COVID-19 vaccination from your dentist

- ☐ No - I am not interested in getting a COVID-19 vaccine at all
- ☐ No - I prefer getting my COVID-19 vaccine from my physician, pharmacist or community health vaccination clinic
- ☐ Not Sure
- ☐ Yes - I would be interested in being vaccinated by my dentist

NOTES AND COMMENTS

Notes/Comments

Once all fields have been completed, save this form as "unverified."

Patient Participation Survey

Subject Study ID _____

Study Name: PREDICT- Pragmatic Return to Effective Dental Infection Control through Triage and Testing

Subject Name: [consent_arm_1][name_last], [consent_arm_1][name_first]

Did you have an opportunity to as questions about the study protocol as part of the consent process (when you were decided whether you wanted to participate or not?)

- ◯ Yes
- ◯ No
- ◯ I didn't need to ask questions

SURVEY ADMINISTRATION

How easy or difficult was it for you to complete the:

	Easy	OK (neither easy nor difficult)	Difficult
a. pre-visit survey which you completed about 2 weeks ago?	◯	◯	◯
b. post-visit survey which you completed right after your dental treatment?	◯	◯	◯

How understandable were questions on the:

	Understandable	OK	No Understandable
a. pre-visit survey which you completed about 2 weeks ago?	◯	◯	◯
b. post-visit survey which you completed right after your dental treatment?	◯	◯	◯

What type of device did you use to complete the Consent and the Pre-Visit Survey?

- ◯ Desktop Computer
- ◯ Laptop Computer
- ◯ Tablet
- ◯ Smartphone

COVID-19 TEST

Did you receive your saliva kit about 1 week prior to your dental visit?

- ◯ Yes
- ◯ No

Indicate how easy or difficult it was to ...

	Easy 1	Neither Easy nor Difficult. 2	Difficult 3
a. follow the instructions for collecting your saliva sample?	◯	◯	◯
b. collect your saliva sample?	◯	◯	◯
c. follow the instructions for packaging your saliva sample?	◯	◯	◯
d. package your saliva sample?	◯	◯	◯
a. have your point-of-care nasal swab test performed?	◯	◯	◯

Did you experience any discomfort when ....

	Yes	No
a. you collected your saliva specimen?	◯	◯
a. You had your nasal swab performed?	◯	◯

TIME TO COMPLETE STUDY ACTIVITIES

How much time did it take for you to ....

	5 minutes	10 minites	15 minutes	20 minutes	25 minutes	30 minutes	>30 minutes
a. provide consent?	◯	◯	◯	◯	◯	◯	◯
b. complete the pre-visit survey?	◯	◯	◯	◯	◯	◯	◯
c. complete the post-visit survey?	◯	◯	◯	◯	◯	◯	◯
d. colect your saliva sample?	◯	◯	◯	◯	◯	◯	◯
d. have your nasal swab performed?	◯	◯	◯	◯	◯	◯	◯
e. travel to/from your dentist office to drop off your saliva sample?	◯	◯	◯	◯	◯	◯	◯
e. receive you test results?	◯	◯	◯	◯	◯	◯	◯

What suggestions do you have to improve the study logistics?

_____

Is the compensations adequate?

◯ Yes
◯ No

Reason for not feeling compensation was adequate

_____

What do you feel would be an adequate compensation amount?

_____

Notes/Comments

Once all fields have been completed, save this form as "unverified."