# COVID-19

PIN Number : W _____ Date : _____

How will these questions be answered?

Please ✓ one box only

| | |
|---|---|
| Self-Report only | |
| Self-Report with support | |
| Proxy only | |

We would like to understand if COVID-19 has affected our IDS-TILDA participants. To help us do this, please answer the following questions.

**1** **Do you/did you have any symptoms of COVID-19?**

Please ✓ one box only

| | |
|---|---|
| Yes | |
| No | |
| Don't know | |

**1a** **If you do/did have symptoms, which ones do/did you have?**

Please ✓ all that apply

| | |
|---|---|
| Fever | |
| Cough | |
| Shortness of breath | |
| Aches and pains | |
| Fatigue | |
| Headache | |
| Sore throat | |
| Feeling sick | |
| Vomiting | |
| Diarrhoea | |
| Loss of sense of smell | |
| Loss of sense of taste | |
| Confusion | |
| Disorientation | |
| Change in mood | |

| | | |
|---|---|---|
| | Change in behaviour | |
| | Other (please specify) | |

**2** **Have you been tested for COVID-19?**

Please ✓ one box only

| | |
|---|---|
| Yes, and testing completed | |
| No, not invited for testing | |
| Invited but did not consent for testing | |
| Invited and testing commenced but not completed | |
| Don't know | |

**If yes, how many times were you tested?**

Please ✓ one box only

| | |
|---|---|
| Once | |
| Twice | |
| Three times | |
| More than three times | |
| Don't know | |
| Not applicable | |

**2a** **If you were tested, please indicate if the test was positive (+) or negative (-)**

Please ✓ all that apply

| | + | - |
|---|---|---|
| First test | | |
| Second test | | |
| Third test | | |
| Fourth test | | |
| Don't know | | |
| Not applicable | | |

| | |
|---|---|
| **3** | **Did you need to move from your usual home due to the COVID-19 crisis?**<br>Please ✓ one box only<br>Yes<br>No<br>Not applicable<br>**If Yes, what was the reason?** |
| **4** | **If you tested positive, and/or had symptoms, did you/your carer have a plan in place to manage the self-isolation as per COVID-19 guidelines**?<br>For example, did you stay away from other people?<br>Please ✓ one box only<br>Yes<br>No<br>Don't know<br>Not applicable |
| **5** | **If you tested positive, and/or had symptoms, were you able to comply with the prevention guidelines on contracting COVID-19?**<br>For example, were you careful about washing your hands or coughing into a tissue?<br>Please ✓ one box only<br>Yes<br>No<br>Don't know<br>Not applicable |
| **6** | **If you tested positive, and/or had symptoms of COVID-19, were you hospitalised?**<br>Please ✓ one box only<br>Yes<br>No<br>Not applicable |

| | |
|---|---|
| **6a** | **If admitted to hospital because of COVID-19, how many days did you spend in hospital?**<br><br>☐ **days(s)** |
| **7** | **If admitted to hospital because of COVID-19, did your treatment require admission to intensive care?**<br>Please ✓ one box only<br>Yes ☐<br>No ☐<br>Don't know ☐<br>Not applicable ☐ |
| **8** | **Did you feel stressed/anxious about COVID-19?**<br>Please ✓ one box only<br>Yes ☐<br>No ☐<br>Don't know ☐ |
| **8a** | **If you did feel stressed/anxious about COVID-19, what was the reason?**<br>Please ✓ all that apply<br>Fear of getting COVID-19 ☐<br>Fear of peers/friends getting COVID-19 ☐<br>Fear of family members getting COVID-19 ☐<br>Isolation ☐<br>Feeling lonely ☐<br>Not being able to do usual activities ☐<br>Not seeing friends ☐<br>Not seeing family ☐<br>Change in staff ☐<br>Not being in my own room or home ☐<br>Not applicable ☐<br>Other (Please give details) ☐ |

| | |
|---|---|
| | |
| **9** | **Were there any good things about the COVID-19 period?**<br>Please ✓ one box only<br>Yes ☐<br>No ☐<br>Don't know ☐ |
| **9a** | **If there were good things during the COVID-19 period, what were they?**<br>For example, things you particularly liked about this recent period, maybe spending time on hobbies, learning new skills, having more free time, etc. |

**Is there any other information you would like to add?**