In order to better serve the needs of all Oregonians, we ask that you complete the following READLD *(Race, Ethnicity, Language, and Disability)* questionnaire. <u>The fields in the box below are REQUIRED</u>, but all other questions are optional. We hope that you will take a moment to complete, thank you.

If you have answered these questions anytime in the last 365 days, you do not need to complete it again.

Today's Date: _____

Event Location: _____

First Name_____

Last Name_____

Date of Birth_____

If under 18, please include parent/guardian name:

First Name_____

Last Name_____

Gender: M F X O R U

(circle one)

Address_____

_____

City, State, Zip_____

County_____

Phone_____

◯ **OPT-OUT. All patients must complete the above information. If you are choosing to opt-out, you may stop here**.
(fill in circle to confirm opt-out)

Are you a tribal member? Y N (circle one)

Are you eligible for IHS, Tribal Health Clinic or UIHP services? Y N (circle one)

<u>Clinical Details</u>

Are you experiencing Covid-19 Symptoms?

Y N (circle one)

Date of Symptom Onset: _____

Symptoms (check all that apply):

__Difficulty breathing __Cough __Feeling feverish
__Muscle pain __Sore throat __Nausea __Chills
__Headache __Loss of sense of taste
__Diarrhea __Nasal congestion __Vomiting
__Shortness of breath __ Loss of sense of smell
__Nasal discharge __Fatigue
__Fever of 100.4°F or higher

<u>Exposure Risk</u>

Is the patient a close contact of a known case?

Y N (circle one)

Additional Information:

_____

_____

<u>Testing Details</u>

Is this the patient's first Covid-19 Test?

Y N (circle one)

Questions continued on next page →

Oregon Department of Human Services

Race, Ethnicity, Language, and Disability (READ)

Oregon Health Authority

These questions are optional and your answers are confidential. We would like you to tell us your race, ethnicity, language and ability levels so that we can find and address health and service differences.

You can get this document in other languages, large print, braille, or a format you prefer. We accept all relay calls or you can dial 711. Please contact The Office of Equity & Inclusion at 971-673-1240

Today's Date: _____ ~~Medical record number~~ (*~~if applicable~~*): _____

First Name: _____ Middle Initial: ____ Last Name: _____ Date of Birth: _____

Race and Ethnicity

1. How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry**?

_____

2. Which of the following describes your **racial or ethnic identity**? Please check **ALL** that apply.

Hispanic and Latino/a/x
- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian and Pacific Islander
- ☐ CHamoru (Chamorro)
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

White
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

American Indian and Alaska Native
- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

Black and African American
- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Other Black

Middle Eastern/North African
- ☐ Middle Eastern
- ☐ North African

Asian
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Other categories
- ☐ Other *(please list)*
- ☐ Don't know
- ☐ Don't want to answer

3. If you checked **more than one** category above, is there **one** you think of as your **primary** racial or ethnic identity?
- ☐ Yes. Please circle your primary racial or ethnic identity above.
- ☐ I do not have just one primary racial or ethnic identity.
- ☐ No. I identify as Biracial or Multiracial.
- ☐ N/A. I only checked one category above.
- ☐ Don't know
- ☐ Don't want to answer

(To be filled in by agency or clinic staff)

Agency or clinic: **Agency staff or provider name or ID:**

Phone: **Address:**

Continued on next page

Language (*Interpreters are available at no charge*)

4a. What language or languages do you **use at home**? _____

Skip to question 7 if you indicated English only

4b. In what language do you want us to communicate in **person, on the phone, or virtually** with you?

_____

4c. In what language do you want us to **write** to you? _____

5a. Do you need or want an **interpreter** for us to communicate with you?

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer

5b. If you need or want an interpreter, what type of interpreter is preferred?

☐ Spoken language interpreter
☐ American Sign Language interpreter
☐ Other ***(please list)***: _____
☐ Deaf Interpreter for DeafBlind, additional barriers, or both
☐ Contact sign language (PSE) interpreter

Skip to question 7 if you do not use a language other than English or sign language

6. How well do you speak English?

☐ Very Well ☐ Well ☐ Not Well ☐ Not at all ☐ Don't know ☐ Don't want to answer

	Your answers will help us find health and service differences among people with and without functional difficulties. Your answers are confidential. (**Please write in "don't know" if you don't know when you acquired this condition, or "don't want to answer" if you don't want to answer the question.*)	Yes	***If yes**, at what age did this condition begin?	No	Don't know	Don't want to answer	Don't know what this question is asking
7.	Are you **deaf** or do you have **serious difficulty hearing**?						
8.	Are you **blind** or do you have **serious difficulty seeing**, even when wearing glasses?						
	Please stop now if you/the person is under age 5						
9.	Do you have **serious difficulty walking or climbing stairs**?						
10.	Because of a physical, mental or emotional condition, do you have **serious difficulty concentrating, remembering or making decisions**?						
11.	Do you have **difficulty dressing or bathing**?						
12.	Do you have **serious difficulty learning how to do things most people your age can learn**?						
13.	Using your **usual (customary) language**, do you have **serious difficulty communicating** (*for example understanding or being understood by others*)?						
	Please stop now if you/the person is under age 15						
14.	Because of a **physical, mental or emotional condition**, do you have **difficulty doing errands alone** such as visiting a doctor's office or shopping?						
15.	Do you have **serious difficulty** with the following: **mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations**?						