



International Maritime Conveyance Illness or Death Investigation Form U.S. Centers for Disease Control and Prevention

If requested by Centers for Disease Control and Prevention (CDC) Quarantine Station, please use this form to submit additional information about the reported onboard illness or death, pursuant to 42 CFR 71.21(a).

- Complete and fax this form to the CDC Quarantine Station to which the illness or death was reported. Quarantine Station jurisdictions and contact information can be found at www.cdc.gov/ncidod/dq/quarantine_stations.htm
- Contact the CDC Quarantine Station to confirm receipt of the faxed report or if you have any questions.
- If you are unable to reach a CDC Quarantine Station, call +1-770-488-7100. Alternate: +1-877-764-5455 (at-sea use).
- Reminder to cruise ships: do not use this form for gastrointestinal (GI) illnesses, which are reportable to CDC Vessel Sanitation Program (VSP) per established protocol. More information about VSP can be found at: <http://www.cdc.gov/nceh/vsp/default.htm> or by calling +1-800-323-2132.

Section 1. Contact information of vessel staff completing form

Name: _____ Title: _____
Telephone: _____ E-mail: _____

Section 2. Vessel information

Vessel name: _____ Vessel company: _____
Embarkation port: _____ Length of voyage: _____ (days)
Next US port: _____ Arrival date/time: ____/____/____
mm dd yyyy (24 hr) hh:mm
Duration of stay at next US port: _____ hours Number (#) on board: Crew: _____; Passengers: _____
List all port stops before arrival: _____
List all port stops after departure from next US port: _____

Section 3. General information on ill or deceased person

Surname/Last Name: _____ Middle name: _____
First/given name: _____ Gender: Male Female Crew Passenger
Occupation (if crew, list job title & duties): _____
Date of birth: ____/____/____ Birth country: _____ Country of residence: _____
mm dd yyyy
Passport Country/Number: _____ Date boarded vessel: ____/____/____ Cabin Number: _____
mm dd yyyy
Home address (street/city): _____ State/Province: _____
Zip/Postal Code: _____ Country: _____ Telephone: _____
Duration of US stay: _____ Contact in US (hotel/address): _____

US City/State: _____

US Telephone: _____

Section 4: Information on signs and symptoms of ill or deceased person

| Signs/ Symptoms (check "yes" if present during illness) | No | Yes | If Yes, provide other information below: |
|--|--------------------------|--------------------------|--|
| Fever or recent history of fever | <input type="checkbox"/> | <input type="checkbox"/> | Onset date: ____/____/_____ mm dd yyyy Maximum measured temperature: °C/°F |
| Rash | <input type="checkbox"/> | <input type="checkbox"/> | Onset date: ____/____/_____ mm dd yyyy Where rash started: <input type="checkbox"/> Head <input type="checkbox"/> Trunk <input type="checkbox"/> Extremities Distribution of rash: <input type="checkbox"/> Head <input type="checkbox"/> Trunk <input type="checkbox"/> Extremities Appearance: <input type="checkbox"/> Red/Flat <input type="checkbox"/> Red/Raised <input type="checkbox"/> Fluid-filled <input type="checkbox"/> Pus-filled <input type="checkbox"/> Other |
| Conjunctivitis (eye redness) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Coryza (runny nose) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Persistent cough | <input type="checkbox"/> | <input type="checkbox"/> | Onset date: ____/____/_____ mm dd yyyy With blood: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know |
| Sore throat | <input type="checkbox"/> | <input type="checkbox"/> | |
| Difficulty breathing / Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | |
| Swollen glands | <input type="checkbox"/> | <input type="checkbox"/> | Onset date: ____/____/_____ mm dd yyyy Location: <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Armpit <input type="checkbox"/> Groin |
| Severe vomiting | <input type="checkbox"/> | <input type="checkbox"/> | Number of times in the last 24 hours: _____ Resulted in dehydration: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know |
| Severe diarrhea (loose stools) | <input type="checkbox"/> | <input type="checkbox"/> | Onset date: ____/____/_____ mm dd yyyy Number of times in the last 24 hours: _____ With blood: <input type="checkbox"/> Yes <input type="checkbox"/> No Resulted in dehydration: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know |
| Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Onset date: ____/____/_____ mm dd yyyy |
| Headache | <input type="checkbox"/> | <input type="checkbox"/> | |
| Neck stiffness | <input type="checkbox"/> | <input type="checkbox"/> | |
| Decreased consciousness (e.g. disoriented) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Recent onset of paralysis and / or focal weakness | <input type="checkbox"/> | <input type="checkbox"/> | |
| Unusual bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Site (explain): |

Describe illness history (e.g., onset date, progression) :

Pre-existing medical conditions: No Yes (if yes, describe)**Section 5. Vaccination and disease history of ill or deceased person****(Skip this section if the presumptive diagnosis is not a vaccine preventable disease)**

Vaccination history (check box if he/she was vaccinated against the disease in the past and fill in number of doses received):

| | | | | | | | |
|----------------------------------|------------------|-------------------------------------|------------------|--|------------------|---|-----------|
| <input type="checkbox"/> Measles | # of doses _____ | <input type="checkbox"/> Pertussis | # of doses _____ | <input type="checkbox"/> Hepatitis A | # of doses _____ | <input type="checkbox"/> Influenza, last received | ____/____ |
| <input type="checkbox"/> Mumps | _____ | <input type="checkbox"/> Diphtheria | _____ | <input type="checkbox"/> Hepatitis B | _____ | | mm yyyy |
| <input type="checkbox"/> Rubella | _____ | <input type="checkbox"/> Varicella | _____ | <input type="checkbox"/> Meningococcal | _____ | <input type="checkbox"/> Other: | _____ |

Disease history (check box if he/she had the disease in the past):

Section 9. Exposure history of ill or deceased person

During the **three weeks before** illness onset, did he/she have contact with:

Other ill person(s)? No Yes

If yes, ill persons' diagnoses or description of illness: _____

Animals/poultry: No Yes If yes, explain: _____

Other exposures (e.g., chemical): No Yes If yes, explain: _____

List places he/she traveled **during 3 weeks** before illness onset (*include ship port stops if disembarked*):

Total # of persons (onboard ship or disembarked) with similar signs and symptoms during the past 3 weeks:
(Please verify by a medical log review): Total # Crew: _____ ; Total # Passengers: _____

Section 10. Traveling companions and other contacts of ill or deceased person

Ill or deceased person isolated after illness onset?: No Yes

If yes:

Date isolated: ____/____/____ Place isolated: Cabin Infirmary Other: _____
mm dd yyyy

Isolated alone: Yes No If no, explain: _____

Did he/she have contact other people after being placed in isolation?: No Yes If yes, identify them by titles or relationships with the ill/deceased person: _____

Answer if ill or deceased person is a crew member:

Write number of :

cabin mates: _____

bathroom mates: _____

work team mates: _____

other contacts (e.g., intimate partners): _____

Do any of above persons have similar signs & symptoms?*

No Yes If yes, explain: _____

Does this crew member eat in passenger venues? No Yes

Does this crew member have contact with passengers?

No Yes If yes, describe extent/frequency: _____

Answer if ill or deceased person is a passenger:

Write number of:

cabin mates: _____

travel companions: _____

other contacts (e.g., intimate partners): _____

Do any of above persons have similar signs & symptoms?*

No Yes If yes, explain: _____

If passenger is a child, does he/she attend day care or youth program on ship? No Yes

If yes, total # of children in day care or program: _____

of children with similar signs & symptoms: _____

***Note:** Submit a separate form for each ill or deceased person not previously reported to a CDC Quarantine Station.

To be completed by quarantine station staff only

Date Quarantine Station notified: ____/____/____
mm/dd/yyyy

Time of initial notification: _____
(24 hr) hh:mm

Final Diagnosis _____ QARS Unique ID # _____

Comments: _____

person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-xxxx.