

International Land Border Illness or Death Investigation Form U.S. Centers for Disease Control and Prevention

QARS Unique ID #: _____

Section 1. Quarantine station notification

Type of notification:	<input type="checkbox"/> Traveler illness <input type="checkbox"/> Traveler death	Date of initial notification:	____/____/____ <i>(mm / dd / yyyy)</i>	Time of initial notification:	____ : ____ <i>(hh : mm)</i>	
Detection of travelers illness or death:		<input type="checkbox"/> Detected on conveyance or at POE <input type="checkbox"/> Detected after departing POE <input type="checkbox"/> Detected while exiting US				
Port of Entry: (or city/region)		State:	Notified by: (name of person)			
Notified by: (name of agency)			Phone:	Email:		
Conveyance type:						
<input type="checkbox"/> Personal vehicle <input type="checkbox"/> Commercial/Cargo vehicle <input type="checkbox"/> Pedestrian/Bike <input type="checkbox"/> Ambulance <input type="checkbox"/> Train <input type="checkbox"/> Bus/Van						
Did illness occur en route?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	If illness occurred en route, was quarantine station notified prior to arrival ?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If illness occurred en route, was illness reported to another agency prior to arrival ?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	If yes, name of agency notified:

Section 2. Information on signs and symptoms of ill or deceased person

Brief history of present illness:

Signs, Symptoms, and Conditions (Check all that apply) :

<input type="checkbox"/> Fever ($\geq 100^{\circ}\text{F}$ or $\geq 37.8^{\circ}\text{C}$) OR recent history of fever Onset date: ____/____/____ If measured, maximum temperature: _____ $^{\circ}\text{F}/^{\circ}\text{C}$	<input type="checkbox"/> Sore throat <input type="checkbox"/> Difficulty breathing / shortness of breath <input type="checkbox"/> Swollen glands <input type="checkbox"/> Severe vomiting <input type="checkbox"/> Severe diarrhea Onset date: ____/____/____ With blood: <input type="checkbox"/> No <input type="checkbox"/> Yes Number of times in past 24 hrs: _____ <input type="checkbox"/> Jaundice Onset date: ____/____/____	<input type="checkbox"/> Decreased consciousness <input type="checkbox"/> Recent onset of focal weakness and/or paralysis <input type="checkbox"/> Unusual bleeding Onset date: ____/____/____ <input type="checkbox"/> Obviously unwell <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Other: _____ <input type="checkbox"/> Cluster of illnesses § Cluster number: _____
<input type="checkbox"/> Rash Onset date: ____/____/____ Where rash started: <input type="checkbox"/> Head <input type="checkbox"/> Trunk <input type="checkbox"/> Extremities Current distribution: <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/Pus filled <input type="checkbox"/> Other: _____ Contact with someone with a rash/chicken pox/rubella in the last 3 weeks? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> Headache <input type="checkbox"/> Neck stiffness	
<input type="checkbox"/> Conjunctivitis / eye redness		
<input type="checkbox"/> Persistent cough Onset date: ____/____/____ With blood: <input type="checkbox"/> No <input type="checkbox"/> Yes		

Presumptive Diagnosis:

Disease of public health importance
 Condition of public health interest / Unknown, needs follow-up

OR

Condition not requiring public health follow-up:
 Affected system: Gastrointestinal Cardiovascular Musculoskeletal Neurologic Psychiatric Respiratory Genitourinary Dermatologic

**If disease of public health importance or condition of public health interest, proceed to next section.
 If condition not requiring public health follow-up, stop here.**

Section 3. General information about the ill or deceased person

Paternal/Last name:	Maternal name:	First name:
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Middle name:		Married name:		Aliases:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Race:		Ethnicity:	Type of traveler:
Border commuter:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Other: _____	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	<input type="checkbox"/> Crew <input type="checkbox"/> Passenger <input type="checkbox"/> N/A
Frequency of border crossing:		Passport #:	Alien #:	Passport country:	
Legal status:			Visa type:		
<input type="checkbox"/> Immigrant	<input type="checkbox"/> Resident Alien	<input type="checkbox"/> Illegal Alien	<input type="checkbox"/> US Citizen	<input type="checkbox"/> Student/Exchange	<input type="checkbox"/> Temporary worker: agriculture
<input type="checkbox"/> Foreign Citizen	<input type="checkbox"/> Refugee/Asylee	<input type="checkbox"/> Unknown		<input type="checkbox"/> Tourist (includes VFR)	<input type="checkbox"/> Humanitarian Parole
			<input type="checkbox"/> Temporary worker: skilled labor	<input type="checkbox"/> Witness/Informant	<input type="checkbox"/> Business <input type="checkbox"/> Diplomatic <input type="checkbox"/> N/A - no visa
Date of birth:	____/____/____ (mm / dd / yyyy)	Age:	<input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Weeks <input type="checkbox"/> Years	Country of birth:	
Home address:		City:	State/Province:	Country of residence:	
ZIP/Postal code:	Home telephone number:	E-mail:	If visiting, total duration of US stay:		<input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> months <input type="checkbox"/> years
Contact in US - Address/hotel:		Contact in US - City:	Contact in US - State/Province:	Contact phone in US:	Number of days reachable at contact phone:
<input type="checkbox"/> Same as above (home address)				<input type="checkbox"/> Cell	_____ days <input type="checkbox"/> Permanent number
Contact information:	<input type="checkbox"/> None <input type="checkbox"/> Unknown	Emergency contact name:	Emergency contact relationship:	Emergency contact phone:	

Section 4. Border Crossing Information

Express lane?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	Attempted entry outside an official POE?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	Was the traveler coming from an airport?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Make/Model/Year:	License plate #:		State issued:	Country issued:	
Company owned?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, specify:	Rental?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, specify:
Did conveyance transport cargo?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, specify:			
Departure city & address:			Departure date:	Departure time:	
<input type="checkbox"/> Unknown			____/____/____ (mm / dd / yyyy)	:____:____ (hh : mm)	
Destination city & address:			Expected arrival date:	Expected arrival time:	
<input type="checkbox"/> Unknown			____/____/____ (mm / dd / yyyy)	:____:____ (hh : mm)	
Route information:					
From (City/Country)	To (City/Country)	Duration of stay	Significant stops	Name of commercial carrier, if applicable	Flight/Bus/Train No.
Segment 1: _____	_____	_____	_____	_____	_____
Segment 2: _____	_____	_____	_____	_____	_____
Segment 3: _____	_____	_____	_____	_____	_____

Section 5. Traveling companions and other contacts of ill or deceased person

If traveling by conveyance, does anyone else on the conveyance have similar illness?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	Number of traveling companions:	Are any traveling companions ill?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A (no companions)
Number of driver(s):	Name of driver(s):		Driver's license number(s):	
_____	1. _____ 2. _____ 3. _____		1. _____ 2. _____ 3. _____	

Section 6. Exposure history of ill or deceased person

Occupation:

During **3 WEEKS** prior to date of illness onset, did traveler have contact with:

Other ill individuals?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	If Yes, ill persons' diagnoses or description of illness:	
Animals or birds? (e.g., visits to zoo, animal market, poultry farm, etc.)	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	If Yes, in which country did contact occur?	Describe nature of contact:
Other exposures? (e.g., chemical, powder, radiation, etc.)	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	If Yes, describe nature of contact:	

Section 7. Vaccination, past illness, and treatment history of ill or deceased person

Does traveler have underlying conditions which may explain the symptoms:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	If yes, describe:	
Vaccination history (check all that apply):	<input type="checkbox"/> Measles <input type="checkbox"/> Varicella <input type="checkbox"/> Rubella <input type="checkbox"/> Pertussis <input type="checkbox"/> Mumps <input type="checkbox"/> Influenza, last received: ____/____/____ <input type="checkbox"/> Meningococcal <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B (mm/yyyy)		
Past illness history (check all that apply):	<input type="checkbox"/> Measles <input type="checkbox"/> Varicella <input type="checkbox"/> Rubella <input type="checkbox"/> Pertussis <input type="checkbox"/> Mumps		
Currently taking medications?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	If Yes, indicate category(ies) of the medication(s) (check all that apply): <input type="checkbox"/> Antibiotic/antimicrobial <input type="checkbox"/> Fever reducing medication <input type="checkbox"/> Other	If Yes, indicate name of medication(s): 1. _____ 2. _____ 3. _____ 4. _____
Treatment given prior to travel?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	If Yes, what was done and by whom?	
Treatment given during travel, but before crossing the border?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	If Yes, what was done and by whom?	
Treatment given at POE?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	If Yes, what was done and by whom?	
Treatment given after crossing the border?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	If Yes, what was done and by whom?	

Section 8. Disposition of ill or deceased person

Ill or deceased person was: (check all that apply)	<input type="checkbox"/> Advised to seek medical care	<input type="checkbox"/> Released to continue travel	<input type="checkbox"/> EMS called	<input type="checkbox"/> Refused entry
	<input type="checkbox"/> Transported to hospital	<input type="checkbox"/> MOA activated	<input type="checkbox"/> Isolated	<input type="checkbox"/> Deceased
	<input type="checkbox"/> Detained by ICE/CBP – Detained at: _____			
	<input type="checkbox"/> Referred to: _____			

Section 9. Agencies contacted

(Agency type key: **F** = Federal, **S** = State, **L** = Local, **P** = Private, **A** = Airport, **X** = Foreign)

Contact name & title	Agency	Type	Phone	E-mail

Additional comments or findings:

Investigation closed Date: _____

Public reporting burden of this collection of information is estimated to average 6 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a 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.