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): _____

OMB Control No 0929-XXXX
Expiration Date: XX/XX/XXXX

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	☐	☐	Onset date: ____/_____/_____ (mm dd yyyy) Maximum measured temperature: °C/°F
Rash	☐	☐	Onset date: ____/_____/_____ (mm dd yyyy) Where rash started: ☐ Head ☐ Trunk ☐ Extremities Distribution of rash: ☐ Head ☐ Trunk ☐ Extremities Appearance: ☐ Red/Flat ☐ Red/Raised ☐ Fluid-filled ☐ Pus-filled ☐ Other
Conjunctivitis (eye redness)	☐	☐	
Coryza (runny nose)	☐	☐	
Persistent cough	☐	☐	Onset date:____/_____/_____ (mm dd yyyy) With blood: ☐ Yes ☐ No ☐ Don't know
Sore throat	☐	☐	
Difficulty breathing / Shortness of breath	☐	☐	
Swollen glands	☐	☐	Onset date:____/_____/_____ (mm dd yyyy) Location: ☐ Head ☐ Neck ☐ Armpit ☐ Groin
Severe vomiting	☐	☐	Number of times in the last 24 hours: _____ Resulted in dehydration: ☐ Yes ☐ No ☐ Don't know
Severe diarrhea (loose stools)	☐	☐	Onset date: _____/_____/_____ (mm dd yyyy) Number of times in the last 24 hours:_____ With blood: ☐ Yes ☐ No Resulted in dehydration: ☐ Yes ☐ No ☐ Don't know
Jaundice	☐	☐	Onset date: ____/_____/_____ (mm dd yyyy)
Headache	☐	☐	
Neck stiffness	☐	☐	
Decreased consciousness (e.g. disoriented)	☐	☐	
Recent onset of paralysis and / or focal weakness	☐	☐	
Unusual bleeding	☐	☐	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):

	# of doses		# of doses		# of doses	
☐ Measles	_____	☐ Pertussis	_____	☐ Hepatitis A	_____	☐ Influenza, last received ____/_____ (mm yyyy)
☐ Mumps	_____	☐ Diphtheria	_____	☐ Hepatitis B	_____	
☐ Rubella	_____	☐ Varicella	_____	☐ Meningococcal	_____	☐ Other:_____

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

☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella ☐ Pertussis ☐ Diphtheria ☐ Hepatitis A ☐ Hepatitis B

Section 6. Information about deaths *(skip to section 7 if not applicable)*

Date of death: ____/____/_____ Time of death: _____ : _____
mm dd yyyy (24 hr) hh : mm

Laboratory test results: _____

Presumptive cause of death: _____

Disposition of body (check one):

☐ Sent to Medical Examiner (city, country): _____

☐ Other: _____

Determined cause of death (by medical examiner or other):

_____

Note: If deceased person did NOT have fever or the suspected cause of death is NOT a communicable disease, STOP and submit form. Otherwise complete rest of the form.

Section 7. Test results of ill or deceased person. *(Skip to section 8 if no tests performed on ship or ashore)*

Tests	Date performed (mm/dd/yyyy)	Results (if unknown, provide name and number of lab which performed tests)
Chest x-ray (radiograph)		
Rapid influenza test		
Legionella urine antigen		
Other Test 1: _____ Test 2: _____ Test 3: _____		

Section 8. Treatment of ill or deceased person

Seen in ship infirmary: ☐ No ☐ Yes
If yes, date of first visit: ____/_____/_____
mm dd yyyy

Check treatments/medications prescribed:
☐ Antibiotics/Antimicrobials: list_____
☐ Fever-reducing medicines (e.g., aspirin, ibuprofen, acetaminophen) _____
☐ Other: list
_____

Presumptive Diagnosis:

_____

Comments:_____

Seen in health-care facility ashore: ☐ No ☐ Yes
If yes, hospitalized ☐ No ☐ Yes
If yes, dates: from: ____/_____/_____ to ____/_____/_____
mm dd yyyy mm dd yyyy

List name (s) and locating information of facility/health-care provider(s) and date(s) of visit:

_____

_____

Treatment: _____

Discharge Diagnosis: _____

Comments:_____

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: ____/____/____ (mm dd yyyy) Place isolated: ☐ Cabin ☐ Infirmary ☐ Other: _____

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 <u>crew member</u>:

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 <u>passenger:</u>

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.