



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. Quarantine Station Notification

Person filling out form:		Phone:		E-mail:	
Date form completed: _____/_____/_____			Time form completed (24 hrs): _____ : _____		
mm dd yyyy		hh : mm			
Type of notification:	<input type="checkbox"/> Traveler illness <input type="checkbox"/> Traveler death	Type of Traveler:	<input type="checkbox"/> Crew <input type="checkbox"/> Passenger	Conveyance type: <input type="checkbox"/> Cruise Ship <input type="checkbox"/> Cargo <input type="checkbox"/> Other	

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

Signs, Symptoms, and Conditions (Check all that apply) :		
<input type="checkbox"/> FEVER ($\geq 100^{\circ}\text{F}$ or $\geq 38^{\circ}\text{C}$) OR history of fever in the past 72 hours Temperature: _____ ^o F/C Onset date: _____/_____/_____ Maximum measured temperature: _____ ^o F/C <input type="checkbox"/> History of fever (not measured) <input type="checkbox"/> Feel warm to the touch <input type="checkbox"/> Rash Onset date: _____/_____/_____ Where rash started: <input type="checkbox"/> Head/neck <input type="checkbox"/> Trunk <input type="checkbox"/> Extremities Current distribution: <input type="checkbox"/> Head/neck <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 _____ <input type="checkbox"/> Conjunctivitis/eye redness <input type="checkbox"/> Coryza/runny nose	<input type="checkbox"/> Persistent cough Onset date: _____/_____/_____ <input type="checkbox"/> With blood <input type="checkbox"/> Without blood <input type="checkbox"/> Sore throat <input type="checkbox"/> Difficulty breathing/shortness of breath <input type="checkbox"/> Swollen glands Location: <input type="checkbox"/> Head/neck <input type="checkbox"/> Armpit <input type="checkbox"/> Groin <input type="checkbox"/> Severe vomiting Onset date: _____/_____/_____ Number of times in past 24 hrs? _____ <input type="checkbox"/> Severe diarrhea Onset date: _____/_____/_____ Number of times in past 24 hrs? _____ <input type="checkbox"/> Jaundice Onset date: _____/_____/_____ <input type="checkbox"/> Headache	<input type="checkbox"/> Neck stiffness <input type="checkbox"/> Decreased consciousness <input type="checkbox"/> Recent onset of focal weakness and/or paralysis <input type="checkbox"/> Unusual bleeding <input type="checkbox"/> Obviously unwell <input type="checkbox"/> Injury <input type="checkbox"/> Chronic condition <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Other: _____ _____ _____

During the past 3 weeks, has anyone (onboard ship or disembarked) had similar signs and symptoms? (Please verify by a medical log review): <input type="checkbox"/> No <input type="checkbox"/> Yes* <input type="checkbox"/> Unknown *If yes, please fill in a new form for each person in the cluster	If yes, total # of ill: Crew: _____ Passengers: _____
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Section 3. Pertinent medical history of ill or deceased person

Relevant history: present illness, other medical problems, vaccinations, etc.:		
Traveler has taken: (include those given on board): <input type="checkbox"/> Antibiotic/antiviral in the past week <input type="checkbox"/> Fever reducing medications in the past 12 hours (e.g. acetaminophen, ibuprofen, aspirin) <input type="checkbox"/> Other	Medication(s) taken: 1. _____ 2. _____ 3. _____	Date(s) started: 1. _____/_____/_____ 2. _____/_____/_____ 3. _____/_____/_____

Seen in ship infirmary: No Yes If yes, date of first visit: ____/____/____
 mm dd yyyy Ill or deceased person isolated after illness onset?: No Yes If yes, date isolated: ____/____/____
 mm dd yyyy
 Suspect Diagnosis: _____

Seen in health-care facility ashore: No Yes Hospitalized? No Yes Dates hospitalized: from ____/____/____ to ____/____/____
 mm dd yyyy mm dd yyyy
 Facility/health care provider(s) info (name, location, dates, telephone number, e-mail):

Discharge Diagnosis: _____

Tests	Date performed (mm/dd/yyyy)	Results (if unknown, provide name and phone number of lab which performed tests):
Chest x-ray:	____/____/____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (<input type="checkbox"/> Cavitation <input type="checkbox"/> No Cavitation)
<i>Legionella</i> urine antigen:	____/____/____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Other: Test 1: _____ Test 2: _____ Test 3: _____	1. ____/____/____ 2. ____/____/____ 3. ____/____/____	1. _____ 2. _____ 3. _____

Section 4. General information about ill or deceased person

Last/paternal name: _____ First/given name: _____
 Middle name: _____ Maternal name (if applicable): _____ Other names used (e.g., former name, alias): _____
 Gender: Male Female Date of birth: ____/____/____ Age (if date of birth unknown): _____
 mm dd yyyy Days Weeks
 Months Years
 Country of birth: _____ Passport country/issuing state: _____ Passport/domestic ID document #: _____ Alien #: _____
 If crew, list job title & duties: _____ Date boarded vessel: ____/____/____ Cabin Number: _____
 mm dd yyyy

For deceased persons, go to Section 5. Otherwise, continue below:

Home address: _____ City: _____ State/province: _____ Zip/postal code: _____
 Country of residence: _____ Home phone: _____ If visiting, total duration of U.S. stay: _____
 days months
 weeks years
 Contact in U.S. – Address/hotel: _____ E-mail: _____
 Same as home address above
 Contact in U.S. - City: _____ Contact in U.S.-State/territory: _____ Contact phone in U.S.: _____
 Cell
 Number of days reachable at contact phone: _____
 Emergency contact name: _____ Emergency contact relationship: _____ Emergency contact phone: _____

Section 5. Vessel information

Vessel name:	Vessel company:	Voyage Number:	Number on board: Crew: Passengers:
Embarkation port:		Embarkation Date: _____/_____/_____ mm dd yyyy	
Disembarkation port:		Disembarkation date: _____/_____/_____ mm dd yyyy	
Next U.S. port:	Arrival date: _____/_____/_____ mm dd yyyy	Arrival time: (24 hr) _____ : _____ hh : mm	Duration of stay at next U.S. port: _____ hrs
Itinerary:			

Section 6. Additional information about deceased person

Date of death: _____/_____/_____ mm dd yyyy	Time of death (24 hr): _____ : _____ hh : mm	
Suspected cause of death before referral to a medical examiner, if body released:		
Body released to medical examiner?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical examiner telephone:	City/Country:
Determined cause of death (by medical examiner or other):		

Note: For deceased persons for whom the suspected cause of death is NOT a communicable disease, stop here. Otherwise, continue to Section 7.

Section 7. Exposure and contact history of ill or deceased person

Cities/states/countries visited in the last 3 WEEKS (include ship port stops if disembarked)	1.	2.	3.	4.
Exposures:	Exposure to ill persons? <input type="checkbox"/> No <input type="checkbox"/> Yes	Exposure to animals?*	Visited rural areas? <input type="checkbox"/> No <input type="checkbox"/> Yes	Other exposures (chemical, drug ingestion, etc)?: <input type="checkbox"/> No <input type="checkbox"/> Yes
*zoos, bush meat, poultry markets, farms, backyard animals				
Describe relevant exposures:				
Are any traveling companions ill?: <input type="checkbox"/> No <input type="checkbox"/> Yes* <input type="checkbox"/> N/A (no companions) If yes, how many are ill: _____				
*Note: Submit a separate form for each ill or deceased person not previously reported to a CDC Quarantine Station.				
Answer if ill or deceased person is a crew member:		Does crew member have contact with passengers?: <input type="checkbox"/> No <input type="checkbox"/> Yes		
Number of : Cabin mates: _____ Bathroom mates: _____ Work team mates: _____ Other contacts (e.g., intimate partners): _____		If yes, describe extent/frequency: _____ _____		
Answer if ill or deceased person is a passenger:		If passenger is a child, does s/he attend day care/youth program on ship?: <input type="checkbox"/> No <input type="checkbox"/> Yes		
Number of: Cabin mates: _____ Other contacts (e.g., intimate partners): _____		If yes, total # of children in day care/program: _____ # of children with similar signs & symptoms: _____		
Comments: _____ _____ _____				

TO BE COMPLETED BY QUARANTINE STAFF ONLY

QARS Unique ID #:	CDC User ID:	Date Quarantine Station received: ____/____/____ mm dd yyyy	Time Quarantine Station received (24 hrs): ____:____ hh:mm
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If ill/deceased person also traveled via Land and/or Air conveyances, please fill out the appropriate form

- When was the QS notified?
- Before any travel was initiated
 - In U.S. jurisdiction
 - In foreign jurisdiction
 - During travel
 - Prior to boarding conveyance
 - While traveler was on a conveyance
 - Inbound to or within U.S. states and territories
 - Outbound from U.S. states and territories
 - After disembarking conveyance
 - After travel completed (reached final destination for that leg of trip)
 - In U.S. jurisdiction
 - In foreign jurisdiction

- Presumptive Diagnosis:**
- Disease of public health interest
 - Condition of public health interest/unknown or cluster, needs follow-up
 - Condition not requiring public health follow-up

- Ill person was (check all that apply):
- Released to continue travel Advised to seek medical care
 - Recommended to not continue travel Seen by EMS Denied boarding
 - Quarantine Order issued Isolation Order issued
 - Detained by ICE/CBP, location: _____
 - Transported to hospital (MOA activated): _____
 - Transported to non-hospital location: _____
 - Other: _____

Public reporting burden of this collection of information is estimated to average 7 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 0920-0821.