



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



Section 1. Quarantine station notification			
QARS Unique ID #:		CDC User ID:	
Port of Entry:		State:	
Person notifying CDC:	Phone:	Email:	
Agency notifying CDC:	Date of initial notification to CDC: _____/_____/_____ mm dd yyyy	Time of initial notification to CDC (24 hrs): _____ : _____ 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 <input type="checkbox"/> N/A	
When was the QS notified?: <input type="checkbox"/> Before any travel was initiated <input type="checkbox"/> In U.S. jurisdiction <input type="checkbox"/> In foreign jurisdiction <input type="checkbox"/> During travel <input type="checkbox"/> Prior to boarding conveyance <input type="checkbox"/> While traveler was on a conveyance <input type="checkbox"/> Inbound to or within U.S. states and territories <input type="checkbox"/> Outbound from U.S. states and territories <input type="checkbox"/> After disembarking conveyance <input type="checkbox"/> After travel completed (reached final destination for that leg of trip) <input type="checkbox"/> In U.S. jurisdiction <input type="checkbox"/> In foreign jurisdiction		Conveyance type*: <input type="checkbox"/> Personal vehicle <input type="checkbox"/> Company owned <input type="checkbox"/> Rental <input type="checkbox"/> Public conveyance bus/van <input type="checkbox"/> Commercial cargo vehicle <input type="checkbox"/> Pedestrian/Bike <input type="checkbox"/> Ambulance <input type="checkbox"/> Train <input type="checkbox"/> Other *If ill/deceased person also traveled via <input type="checkbox"/> Air and/or <input type="checkbox"/> Maritime conveyances, please fill out the appropriate form and attach	

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"/> Other: _____ _____ _____
If traveling by conveyance, does anyone else have similar illness?: <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.)		

Presumptive Diagnosis:

- Disease of public health interest or any death (**proceed to next section**)
 Condition of public health interest/unknown or cluster, needs follow-up (**proceed to next section**)
 Condition not requiring public health follow-up (**STOP HERE**)

Section 3. Pertinent medical history of ill person

Relevant history: present illness, other medical problems, vaccinations, etc.:

Traveler has taken: Antibiotic/antiviral in the **past week** Medication(s) taken: Date(s) started:
 Fever reducing medications in the **past 12 hours** 1. _____ 1. ____/____/____
(e.g. acetaminophen, ibuprofen, aspirin) 2. _____ 2. ____/____/____
 Other 3. _____ 3. ____/____/____

Section 4. General information about the 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth: ____/____/____ mm dd yyyy	Age (if date of birth unknown):	<input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> months <input type="checkbox"/> years
Country of birth:	Border commuter: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Frequency of border crossing: _____ times/	<input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year
Passport country:	Passport country/issuing state:	Passport/domestic ID document #:	Visa?: <input type="checkbox"/> Yes <input type="checkbox"/> No

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

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

Section 5. Border Crossing Information

Make/Model/Year:	License plate #:	State/country issued:
Attempted entry outside an official POE?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	Contact information collected on conveyance passengers/driver(s)?: <input type="checkbox"/> No <input type="checkbox"/> Yes	

From (City/Country)	Departure date	To (City/Country)	Arrival date	Significant stops	Name of commercial carrier, if applicable	Bus/Train #	Seat #
Current Segment:							
Past & Upcoming Segments:							

Section 6. General information about the deceased person

Date of death:	____/____/____ mm dd yyyy	Time of death (24 hours):	____ : ____ hh : mm
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Suspected cause of death before referral to medical examiner, if body released:

Body released to medical examiner?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical examiner telephone:	City/Country:
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Determined cause of death (by medical examiner or other):

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	1.	2.	3.	4.
Exposures:	Exposure to ill persons? <input type="checkbox"/> Yes <input type="checkbox"/> No	Exposure to animals? * <input type="checkbox"/> Yes <input type="checkbox"/> No	Visited rural areas? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other exposures (chemical, drug ingestion, etc): <input type="checkbox"/> Yes <input type="checkbox"/> No

*zoos, bush meat, poultry markets, farms, backyard animals

Describe relevant exposures:

Are any traveling companions ill: No Yes N/A (no companions) If yes, how many ill: _____

If yes, use another illness screening and response worksheet for each.

Section 8. Disposition of ill person

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

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 0920-0821