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: _____/_____/_____ (mm / dd / yyyy)

Time form completed (24 hrs): _____ : _____ (hh : mm)

Type of notification: ☐ Traveler illness ☐ Traveler death

Type of Traveler: ☐ Crew ☐ Passenger

Conveyance type: ☐ Cruise Ship ☐ Cargo ☐ Other

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

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

☐ **FEVER** (≥100˚F or ≥38°C)
OR history of fever in the past 72 hours

Temperature: _____ ⁰ F/C
Onset date: _____/_____/_____
Maximum measured temperature: _____ ⁰ F/C

☐ History of fever (not measured)
☐ Feel warm to the touch

☐ Rash
Onset date: _____/_____/_____
Where rash started:
☐ Head/neck ☐ Trunk ☐ Extremities
Current distribution:
☐ Head/neck ☐ Trunk ☐ Extremities
Appearance:
☐ Red-flat ☐ Red-raised
☐ Fluid/pus-filled ☐ Other _____

☐ Conjunctivitis/eye redness

☐ Coryza/runny nose

☐ Persistent cough
Onset date: _____/_____/_____
☐ With blood ☐ Without blood

☐ Sore throat

☐ Difficulty breathing/shortness of breath

☐ Swollen glands
Location: ☐ Head/neck ☐ Armpit ☐ Groin

☐ Severe vomiting
Onset date: _____/_____/_____
Number of times in past 24 hrs? _____

☐ Severe diarrhea
Onset date: _____/_____/_____
Number of times in past 24 hrs? _____

☐ Jaundice
Onset date: _____/_____/_____

☐ Headache

☐ Neck stiffness

☐ Decreased consciousness

☐ Recent onset of focal weakness and/or paralysis

☐ Unusual bleeding

☐ Obviously unwell

☐ Injury

☐ Chronic condition

☐ Asymptomatic

☐ Other: _____

_____

_____

During the past 3 weeks, has anyone (onboard ship or disembarked) had similar signs and symptoms? (Please verify by a medical log review):

☐ No
☐ Yes*
☐ Unknown

***If yes, please fill in a new form for each person in the cluster**

If yes, total # of ill: Crew: _____ Passengers: _____

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):

☐ Antibiotic/antiviral in the **past week**
☐ Fever reducing medications in the **past 12 hours** (e.g. acetaminophen, ibuprofen, aspirin)
☐ Other

Medication(s) taken:
1. _____
2. _____
3. _____

Date(s) started:
1. ____/____/_____
2. ____/____/_____
3. ____/____/_____

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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 _____/_____/_____ (mm dd yyyy) to _____/_____/_____ (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:	_____/_____/_____	☐ Normal ☐ Abnormal (☐ Cavitation ☐ No Cavitation)
Legionella urine antigen:	_____/_____/_____	☐ Positive ☐ 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: _____/_____/_____ (mm dd yyyy)	Age (if date of birth unknown): ☐ 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: _____/_____/_____ (mm dd yyyy)	Cabin Number:	

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: ☐ Same as home address above		E-mail:	
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:	

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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?: ☐ Yes ☐ 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? ☐ No ☐ Yes	Exposure to animals?* ☐ No ☐ Yes	Visited rural areas? ☐ No ☐ Yes	Other exposures (chemical, drug ingestion, etc)?: ☐ No ☐ Yes

*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 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 <u>crew member</u>:
Number of : Cabin mates:_____
Bathroom mates: _____
Work team mates: _____
Other contacts (e.g., intimate partners): _____

Does crew member have contact with passengers?: ☐ No ☐ Yes
If yes, describe extent/frequency:
_____
_____

Answer if ill or deceased person is a <u>passenger:</u>
Number of: Cabin mates: _____
Other contacts (e.g., intimate partners):_____

If passenger is a child, does s/he attend day care/youth program on ship?: ☐ No ☐ Yes
If yes**,** total # of children in day care/program: _____
# of children with similar signs & symptoms: _____

Comments: _____
_____
_____

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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

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: _____

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