

Optional General Maritime Contact Investigation Outcome Reporting Form

1. PASSENGER CONTACT INFORMATION						
Last name, First name	Cabin #	Sex	DOB (mm/dd/yy) OR	Age (yrs)	Country of birth	Country of residence
(Auto-populated)						
Was contact a passenger or crew member? <input type="checkbox"/> Passenger <input type="checkbox"/> Crew member, specify occupation _____						
2. CONTACT INVESTIGATION OUTCOME FOR ABOVE NAMED CONTACT						
Is contact still on this ship?						
<input type="checkbox"/> Yes, date due to disembark: __/__/____						
<input type="checkbox"/> No, why not?						
<input type="checkbox"/> Returned to country of residence						
<input type="checkbox"/> Transferred to another ship of the same company						
<input type="checkbox"/> Disembarked in another country (specify): _____, Location (specify address): _____						
<input type="checkbox"/> Other; _____ <input type="checkbox"/>						
Additional comments:						
3. INTERVIEW INFORMATION						
Was contact interviewed?						
<input type="checkbox"/> No, why not? <input type="checkbox"/> Declined <input type="checkbox"/> Other (specify) _____ (Stop here)						
<input type="checkbox"/> Yes (Continue)						
If contact is a woman of child-bearing age, is she pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes; what trimester at the time of travel? <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd						
Is the contact immunocompromised? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: _____ <input type="checkbox"/> Unknown						
Relationship to index case:						
<input type="checkbox"/> Workmate <input type="checkbox"/> Cabinmate <input type="checkbox"/> Tablemate <input type="checkbox"/> Shared bathroom facilities <input type="checkbox"/> Other, specify _____						
Date of last exposure to index case: __/__/____						
Duration of contact with index case _____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days						
Did this person know of anyone else from the conveyance who may have developed this disease as a result of this exposure?						
<input type="checkbox"/> No <input type="checkbox"/> Yes; Who? _____ <input type="checkbox"/> Unknown						
Did contact receive a notification letter from the ship? <input type="checkbox"/> No <input type="checkbox"/> Yes						
4. HISTORY OF THIS DISEASE OR VACCINE						
History of disease:						
<input type="checkbox"/> No						
<input type="checkbox"/> Yes; Approximate date __/__/____ or age (yrs) ____ when had [this disease] , Was the diagnosis confirmed by a health care provider? <input type="checkbox"/> No <input type="checkbox"/> Yes						
<input type="checkbox"/> Unknown						
History of vaccination:						
<input type="checkbox"/> No						
<input type="checkbox"/> Yes; Number of doses of (disease auto-populated) -containing vaccine _____, <input type="checkbox"/> <input type="checkbox"/> Unknown						
Is there written documentation of vaccination? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Approximate dates or age received: 1. __/__/____ or age ____;						
2. __/__/____ or age ____;						
3. __/__/____ or age ____;						
4. __/__/____ or age ____;						
5. __/__/____ or age ____						
<input type="checkbox"/> Unknown						
Serologic proof of immunity? <input type="checkbox"/> No <input type="checkbox"/> Yes; Is there written documentation? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Is the contact considered susceptible? <input type="checkbox"/> No <input type="checkbox"/> Yes						
5. INTERVENTION RELATED TO EXPOSURE ON THE CONVEYANCE						
Did contact receive prophylaxis for this exposure? <input type="checkbox"/> No <input type="checkbox"/> Yes						
If no, please check why not:						
<input type="checkbox"/> Outside window for prophylaxis						
<input type="checkbox"/> Within window for prophylaxis but declined						
<input type="checkbox"/> Other (specify): _____						
If yes, please check what the contact received and the date (mm/dd/yy) :						
<input type="checkbox"/> Antimicrobial drug, Date received: __/__/____						
<input type="checkbox"/> Vaccination for this disease; Date received: __/__/____						
<input type="checkbox"/> Immunoglobulin; Date received: __/__/____						
Was contact quarantined alone? <input type="checkbox"/> No <input type="checkbox"/> Yes; /cohorted with others? <input type="checkbox"/> No <input type="checkbox"/> Yes						
<input type="checkbox"/> Yes, how many days? _____						

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No

6. HEALTH SINCE TRAVEL: FIRST INTERVIEW DONE LESS THAN ONE INCUBATION PERIOD SINCE TRAVEL

NOTE: If your first interview was after the incubation period (># days since travel, please skip to section 7

Interview Date: ___/___/___

Did contact report any signs or symptoms? No (**Stop here**) Yes; please check all that apply:

- Fever; Date of onset: ___/___/___, Maximum measured temperature _____°C/F
- Feverishness (no temperature measured): ___/___/___
- Cough; Date of onset: ___/___/___
- Rash; Date of onset: ___/___/___
- Coryza; Date of onset: ___/___/___
- Conjunctivitis; Date of onset: ___/___/___
- Sore throat; Date of onset: ___/___/___
- Swollen glands; Date of onset: ___/___/___
- Vomiting; Date of onset: ___/___/___
- Diarrhea; Date of onset: ___/___/___
- Jaundice; Date of onset: ___/___/___
- Headache; Date of onset: ___/___/___
- Neck stiffness; Date of onset: ___/___/___
- Unusual bleeding; Date of onset: ___/___/___
- Decreased consciousness; Date of onset: ___/___/___
- Difficulty breathing/shortness of breath; Date of onset: ___/___/___
- Recent onset of focal weakness and/or paralysis; Date of onset: ___/___/___

7. HEALTH SINCE TRAVEL: INTERVIEW DONE AT LEAST ONE INCUBATION PERIOD SINCE TRAVEL

Interview Date: ___/___/___

N/A (did not follow-up with passenger after first interview)

Did contact report any signs or symptoms? No (**Stop here**) Yes; please check all that apply:

- Fever; Date of onset: ___/___/___, Maximum measured temperature _____°C/F
- Feverishness (no temperature measured): ___/___/___
- Cough; Date of onset: ___/___/___
- Rash; Date of onset: ___/___/___
- Coryza; Date of onset: ___/___/___
- Conjunctivitis; Date of onset: ___/___/___
- Sore throat; Date of onset: ___/___/___
- Swollen glands; Date of onset: ___/___/___
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- Headache; Date of onset: ___/___/___
- Neck stiffness; Date of onset: ___/___/___
- Unusual bleeding; Date of onset: ___/___/___
- Decreased consciousness; Date of onset: ___/___/___
- Difficulty breathing/shortness of breath; Date of onset: ___/___/___
- Recent onset of focal weakness and/or paralysis; Date of onset: ___/___/___

8. DIAGNOSIS

If contact reported symptoms, was s/he evaluated by a health care provider? No Yes; Date(s): ___/___/___; ___/___/___

If yes, was the contact diagnosed with **[this disease]**? No Yes; Date: ___/___/___ Insufficient Information

How was diagnosis made?

IgM Paired IgG PCR Culture Epi-linked Clinical diagnosis only Other (specify): _____

Did the infection develop within the incubation period? No Yes

Has anyone else developed **[this disease]** as a result of exposure to this person? No Yes; Who? _____

Was this passenger a close contact of the index case other than on the conveyance?

No Yes, type: Household Travel companion Social Work Other _____

Is this passenger a close contact with a known case of **[this disease]** other than the person on the conveyance?

No Yes; with whom? _____ Date of last exposure (mm/dd): ___/___ Unknown

Has contact visited other countries during the past month? No Unknown Yes

If yes, list the country with the corresponding dates (mm/dd):

1. _____ From: ___/___ to ___/___
2. _____ From: ___/___ to ___/___

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3. _____ From: ____/____ to ____/____

9. COMMENTS [free text field]

Public reporting burden of this collection of information is estimated to average 5 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