



Maritime Conveyance Illness or Death Investigation Form

U.S. Centers for Disease Control and Prevention

Form Approved
OMB Control No.0920-0821
Exp XX/XX/XXXX

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 where the illness or death was reported. Quarantine Station jurisdictions and contact information can be found at <http://www.cdc.gov/quarantine/QuarantineStationContactListFull.html>
- 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:
Type of notification: <input type="checkbox"/> Illness <input type="checkbox"/> Death		Type of Traveler:		Conveyance type: <input type="checkbox"/> Cruise Ship <input type="checkbox"/> Cargo <input type="checkbox"/> Other _____
		<input type="checkbox"/> Crew <input type="checkbox"/> Passenger		
Section 2: Vessel Information				
Vessel company:		Vessel name:		Voyage Number:
				Number on board: Crew: _____ Passengers: _____
Country of departure:		Departure date & time (24 hr): ____/____/____, ____:____ mm dd yyyy hh : mm		Arrival date & time (24hr) at final port: ____/____/____, ____:____ mm dd yyyy hh : mm
Itinerary:				
Next U.S. port:			Arrival date & time (24 hr) at next U.S. port : ____/____/____, ____:____ mm dd yyyy hh : mm	
Person info while onboard vessel:				
Cabin number:		If crew, list job title & duties:		If crew member has contact with passengers, describe extent/frequency:
Embarkation port:		Embarkation date: ____/____/____ mm dd yyyy		Disembarkation port:
				Disembarkation date: ____/____/____ mm dd yyyy
Section 3: Pertinent medical history of ill or deceased person				
Relevant history: present illness, other medical problems, vaccinations, overseas physician diagnosis, etc.:				
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 feeling feverish/ having chills in past 72 hrs Onset date: ____/____/____ Current temperature: ____ ^o F/C <input type="checkbox"/> Rash Onset date: ____/____/____ Appearance: <input type="checkbox"/> Maculopapular <input type="checkbox"/> Vesicular/Pustular <input type="checkbox"/> Purpuric/Petechial <input type="checkbox"/> Scabbed <input type="checkbox"/> Other _____ <input type="checkbox"/> Conjunctivitis/eye redness Onset date: ____/____/____ <input type="checkbox"/> Coryza/runny nose Onset date: ____/____/____ <input type="checkbox"/> Persistent cough Onset date: ____/____/____ <input type="checkbox"/> With blood <input type="checkbox"/> Without blood <input type="checkbox"/> Sore throat Onset date: ____/____/____		<input type="checkbox"/> Difficulty breathing/shortness of breath Onset date: ____/____/____ <input type="checkbox"/> Swollen glands Onset date: ____/____/____ Location: <input type="checkbox"/> Head/neck <input type="checkbox"/> Armpit <input type="checkbox"/> Groin <input type="checkbox"/> Vomiting Onset date: ____/____/____ # of times in past 24 hrs? ____ <input type="checkbox"/> Diarrhea Onset date: ____/____/____ # of times in past 24 hrs? ____ <input type="checkbox"/> Jaundice Onset date: ____/____/____ <input type="checkbox"/> Headache Onset date: ____/____/____ <input type="checkbox"/> Neck stiffness Onset date: ____/____/____		<input type="checkbox"/> Decreased consciousness Onset date: ____/____/____ <input type="checkbox"/> Recent onset of focal weakness and/or paralysis Onset date: ____/____/____ <input type="checkbox"/> Unusual bleeding Onset date: ____/____/____ <input type="checkbox"/> Obviously unwell <input type="checkbox"/> Chronic condition <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Injury <input type="checkbox"/> Other Signs, Symptoms, Conditions: _____ _____
Deceased Persons:				

Date of death: ____/____/____
mm dd yyyy

Time of death (24 hours): ____:____
hh : mm

Presumptive diagnosis/cause of death:

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*, total # ill of crew _____, passengers _____
 Unknown

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

NOTE: STOP HERE IF THIS REPORT IS FOR A SIMPLE, UNCOMPLICATED CASE OF VARICELLA OR IS SUSPECTED.

Section 4. Evaluation of ill or deceased person

Traveler has taken (include those given on board):

- Antibiotic/antiviral/antiparasitic(s) in the **past week**; list with dates started: _____
 Fever-reducing medications (e.g. acetaminophen, ibuprofen) in the **past 12 hours**; list with dates started: _____
 Other (related to current symptoms/illness); list with date(s) started: _____

Countries visited in the past 3 weeks:	State/city/village	Arrival Date	Exposure to ill persons?	Exposure to animals?	Other exposures (chemical, drug ingestion, etc)?
			<input type="checkbox"/> No <input type="checkbox"/> Yes, _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____
			<input type="checkbox"/> No <input type="checkbox"/> Yes, _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____
			<input type="checkbox"/> No <input type="checkbox"/> Yes, _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____

Number of potentially exposed contacts (e.g. cabin, work, bathroom mates): _____

Are any traveling companions ill? No Yes*, how many are ill: _____ N/A (no companions)

If passenger is a child, does s/he attend day care/youth program on ship?:

- No Yes, total # of children in day care/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.

Seen in ship infirmary:

- No
 Yes, date of first visit: ____/____/____
mm dd yyyy
 No infirmary

Ill/deceased person isolated after illness onset?:

- No
 Yes, date isolated: ____/____/____
mm dd yyyy

Seen in health-care facility ashore:

- No
 Yes; facility/health care provider(s) information (name, location, dates, telephone number, e-mail):

Hospitalized?

- No
 Yes, dates hospitalized: from ____/____/____
to ____/____/____
mm dd yyyy

Lab/Imaging Results

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

Deceased Persons:

Body released to medical examiner?: No Yes, telephone: _____ City/Country: _____

Discharge/final diagnosis/cause of death (determined by medical examiner or other):

Section 5. 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: <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:	Passport country/citizenship:	Type of ID document:	ID document #: Alien #:
Home address:	City:	State/province:	Zip/postal code:
Country of residence:	Home phone:	If visiting, total duration of U.S. stay: <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Weeks <input type="checkbox"/> Years	
Contact in U.S. – Address/hotel: <input type="checkbox"/> Same as home address above		E-mail:	
Contact in U.S. - City:	Contact in U.S.-State/territory:	Contact phone in U.S.: <input type="checkbox"/> Cell # of days reachable at contact phone: ____	
Emergency contact name:	Emergency contact relationship:	Emergency contact phone:	
Comments: _____ _____			
TO BE COMPLETED BY QUARANTINE STAFF ONLY			
QARS Unique ID #:	CDC User ID:	Date Quarantine Station notified: ____/____/____	Time Quarantine Station notified (24 hrs) ____:____
When was the Quarantine Station notified? <input type="checkbox"/> Before any travel was initiated <input type="checkbox"/> During travel <input type="checkbox"/> Prior to boarding conveyance <input type="checkbox"/> While traveler was on a conveyance <input type="checkbox"/> After disembarking conveyance <input type="checkbox"/> After travel completed (reached final destination for that leg of trip) <input type="checkbox"/> Unknown		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"/> EMS responded <input type="checkbox"/> Recommended to not continue travel <input type="checkbox"/> Transported to hospital (<input type="checkbox"/> MOA activated): _____ <input type="checkbox"/> Transported to non-hospital location: _____ <input type="checkbox"/> Detained by law enforcement, location: _____ <input type="checkbox"/> Denied boarding by law enforcement <input type="checkbox"/> Other: _____	
Where was the traveler when the QS was notified?: <input type="checkbox"/> In U.S. jurisdiction (within 3 nautical miles of U.S. coast or traveling between U.S. ports) <input type="checkbox"/> Outside U.S. jurisdiction <input type="checkbox"/> Unknown		Response or Report: <input type="checkbox"/> Requires DGMQ Response & Follow-Up <input type="checkbox"/> Information Report Only / No Follow-Up Needed	
NOTE: If ill/deceased person also traveled via <input type="checkbox"/> Land and/or <input type="checkbox"/> Air conveyances, please fill out the appropriate form			

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.