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: ☐ Illness ☐ Death	Type of Traveler: ☐ Crew ☐ Passenger	Conveyance type: ☐ Cruise Ship ☐ Cargo ☐ Other ______________

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) :

☐ FEVER (≥100˚F or ≥38°C) **OR** history of feeling feverish/ having chills in past 72 hrs
Onset date:_____/_____/______
Current temperature: _____⁰ F/C

☐ Rash
Onset date: _____/_____/______
Appearance:
☐ Maculopapular ☐Vesicular/Pustular
☐ Purpuric/Petechial ☐ Scabbed ☐ Other ________

☐ Conjunctivitis/eye redness
Onset date: ____/_____/____

☐ Coryza/runny nose
Onset date: ____/_____/____

☐ Persistent cough
Onset date: ___/____/___
☐ With blood ☐ Without blood

☐ Sore throat
Onset date: _____/_____/______

☐ Difficulty breathing/shortness of breath
Onset date: _____/_____/______

☐ Swollen glands
Onset date: ____/_____/____
Location: ☐ Head/neck ☐ Armpit ☐ Groin

☐ Vomiting
Onset date: ___/___/__
# of times in past 24 hrs? _____

☐ Diarrhea
Onset date: _____/_____/______
# of times in past 24 hrs?___

☐ Jaundice
Onset date: _____/_____/______

☐ Headache
Onset date: ____/_____/____

☐ Neck stiffness
Onset date: ____/____/______

☐ Decreased consciousness
Onset date: _____/_____/_____

☐ Recent onset of focal weakness and/or paralysis
Onset date: ____/____/____

☐ Unusual bleeding
Onset date: _____/____/____

☐ Obviously unwell

☐ Chronic condition

☐ Asymptomatic

☐ Injury

☐ 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):

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

☐ No
☐ Yes*, total # ill of crew __________, passengers __________
☐ Unknown

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)?
			☐ No ☐Yes, ____________	☐ No ☐Yes, ____________	☐ No ☐Yes, ____________
			☐ No ☐Yes, ____________	☐ No ☐Yes, ____________	☐ No ☐Yes, ____________
			☐ No ☐Yes, ____________	☐ No ☐Yes, ____________	☐ No ☐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:	______/______/______	☐ Normal ☐ Abnormal (☐ Cavity ☐ No cavity)
Legionella urine antigen:	______/______/______	☐ Positive ☐ Negative
Test 1: ______________________ Test 2: ______________________ Test 3: ______________________	1. ______/______/______ 2. ______/______/______ 3. _____/______/_______	1. ______________________ 2.______________________ 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

<table>
<tr><td colspan="3">Last/paternal name:</td><td colspan="3">First/given name</td></tr>
<tr><td>Middle name:</td><td colspan="3">Maternal name (if applicable):</td><td colspan="2">Other names used (e.g., former name, alias):</td></tr>
<tr><td>Gender:
☐ Male ☐ Female</td><td colspan="3">Date of birth: ________/_________/_______
mm dd yyyy</td><td colspan="2">Age (if date of birth unknown): ☐ Days ☐ Weeks ☐ Months ☐ Years</td></tr>
<tr><td>Country of birth:</td><td>Passport country/citizenship:</td><td colspan="2">Type of ID document:</td><td>ID document #:</td><td>Alien #:</td></tr>
<tr><td>Home address:</td><td colspan="3">City:</td><td>State/province:</td><td>Zip/postal code:</td></tr>
<tr><td>Country of residence:</td><td colspan="3">Home phone:</td><td colspan="2">If visiting, total duration of U.S. stay: ☐ Days ☐ Months ☐ Weeks ☐ Years</td></tr>
<tr><td colspan="4">Contact in U.S. – Address/hotel:
☐ Same as home address above</td><td colspan="2">E-mail:</td></tr>
<tr><td>Contact in U.S. - City:</td><td colspan="3">Contact in U.S.-State/territory:</td><td colspan="2">Contact phone in U.S.:
☐ Cell # of days reachable at contact phone: ____</td></tr>
<tr><td>Emergency contact name:</td><td colspan="3">Emergency contact relationship:</td><td colspan="2">Emergency contact phone:</td></tr>
<tr><td colspan="6">Comments:
____
____</td></tr>
<tr><td colspan="6">TO BE COMPLETED BY QUARANTINE STAFF ONLY</td></tr>
<tr><td>QARS Unique ID #:</td><td colspan="2">CDC User ID:</td><td colspan="2">Date Quarantine Station notified:
_____/_____/______</td><td>Time Quarantine Station notified (24 hrs)
______:______</td></tr>
<tr><td colspan="3">When was the Quarantine Station notified?
☐ Before any travel was initiated
☐ During travel
☐ Prior to boarding conveyance
☐ While traveler was on a conveyance
☐ After disembarking conveyance
☐ After travel completed (reached final destination for that leg of trip)
☐ Unknown</td><td colspan="3">Ill person was (check all that apply):
☐ Released to continue travel
☐ Advised to seek medical care
☐ EMS responded
☐ Recommended to not continue travel
☐ Transported to hospital (☐ MOA activated): ________________
☐ Transported to non-hospital location: ______________________
☐ Detained by law enforcement, location: ________________________
☐ Denied boarding by law enforcement
☐ Other: ____</td></tr>
<tr><td colspan="3">Where was the traveler when the QS was notified?:
☐ In U.S. jurisdiction (within 3 nautical miles of U.S. coast or traveling between U.S. ports)
☐ Outside U.S. jurisdiction
☐ Unknown</td><td colspan="3">Response or Report:
☐ Requires DGMQ Response & Follow-Up
☐ Information Report Only / No Follow-Up Needed</td></tr>
<tr><td colspan="6">NOTE: If ill/deceased person also traveled via ☐ Land and/or ☐ Air conveyances, please fill out the appropriate form</td></tr>
</table>

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.