

## **Appendix 1: CCHF Case Investigation Questionnaire**

**CCHF Case Investigation Questionnaire**

No

Name of examiner \_\_\_\_\_ Date of filling \_\_\_\_/\_\_\_\_/\_\_\_\_

No of history record  
Hospitalization  Y  N  
Hospital name \_\_\_\_\_  
Date of hospitalization \_\_\_\_/\_\_\_\_/2011

**Demographic data**

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  M  F  
Residence located in:  
Rayon: \_\_\_\_\_ Sub-district: \_\_\_\_\_  
Employed  yes  no

Occupation \_\_\_\_\_  
Kind of activity \_\_\_\_\_

**Risk factors for CCHF (within 2 weeks before developing a fever)**

Tick bite  Y  N  
Date of tick bite: \_\_\_\_/\_\_\_\_/\_\_\_\_

Livestock activity  Y  N  
Species contacted: \_\_\_\_\_

Slaughtering livestock  Y  N  
Species contacted: \_\_\_\_\_

Butchering/handling raw meat  Y  N  
Type of meat handled(species): \_\_\_\_\_

Nursing for person with bleeding  Y  N

Handling ticks with bare hands  Y  N

Seeking of medical care due to tick bite  Y  N  
Date of seeking of medical care: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical facility: \_\_\_\_\_

Geographic location of tick bite Rayon: \_\_\_\_\_ Sub-district: \_\_\_\_\_

Number of ticks removed: \_\_\_\_  
Tick ID # \_\_\_\_\_ Species: \_\_\_\_\_

**Clinical data**

Date of symptom/illness onset \_\_\_\_/\_\_\_\_/2011 resolved: \_\_\_\_/\_\_\_\_/2011  
Fever  Y  N onset date: \_\_\_\_/\_\_\_\_/2011 resolved: \_\_\_\_/\_\_\_\_/2011  
Headache  Y  N onset date: \_\_\_\_/\_\_\_\_/2011 resolved: \_\_\_\_/\_\_\_\_/2011  
Myalgia/muscle ache  Y  N onset: \_\_\_\_/\_\_\_\_/2011 resolved: \_\_\_\_/\_\_\_\_/2011



Total volume/units given: \_\_\_\_\_

Date of discharge from the hospital: \_\_\_\_/\_\_\_\_/2011r.

Diagnosis: \_\_\_\_\_  
 Suspect     Probable     Confirmed     Negative

**Outcome**

survived     died     unknown

If patient died, date of death: \_\_\_\_/\_\_\_\_/2011

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**Diagnostic Tests Performed**

Blood collection #1

Date of blood collection \_\_\_\_/\_\_\_\_/\_\_\_\_

CCHF diagnostic testing

Tests	Result		
IgM ELISA	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain
IgG ELISA	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain
Antigen ELISA	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain
PCR	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain

Other relevant test results: \_\_\_\_\_

Blood collection #2

Date of blood collection \_\_\_\_/\_\_\_\_/\_\_\_\_

CCHF diagnostic testing

Tests	Result		
IgM ELISA	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain
IgG ELISA	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain
Antigen ELISA	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain
PCR	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain

Other relevant test results: \_\_\_\_\_

Blood collection #3

Date of blood collection \_\_\_\_/\_\_\_\_/\_\_\_\_

CCHF diagnostic testing

Tests	Result		
IgM ELISA	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain
IgG ELISA	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain
Antigen ELISA	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain
PCR	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain

Other relevant test results: \_\_\_\_\_

**Tissue Collection**

Date of Tissue collection: \_\_\_\_/\_\_\_\_/\_\_\_\_

Tissues sampled:  Liver     Spleen     Blood clot     Lymph node     other:

CCHF diagnostic testing

Tests	Result		
Antigen ELISA	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain
PCR	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain

Other relevant test results: \_\_\_\_\_

Tick testing for CCHF

Date of test: \_\_\_\_/\_\_\_\_/\_\_\_\_

Antigen ELISA	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain
PCR	<input type="checkbox"/> positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Uncertain