

**Appendix 1:**

**VIRAL HEMORRHAGIC FEVER  
CASE INVESTIGATION FORM**

# VIRAL HEMORRHAGIC FEVER CASE INVESTIGATION FORM

Outbreak  
Case ID:

Health  
Facility  
Case ID:

Date of Case Report: \_\_\_/\_\_\_/\_\_\_ (D, M, Yr)

## Section 1. Patient Information

Patient's Surname: \_\_\_\_\_ Other Names: \_\_\_\_\_ Age: \_\_\_\_\_  Years  Months  
Gender:  Male  Female Phone Number of Patient/Family Member: \_\_\_\_\_ Owner of Phone: \_\_\_\_\_

Status of Patient at Time of This Case Report:  Alive  Dead *If dead, Date of Death: \_\_\_/\_\_\_/\_\_\_ (D, M, Yr)*

### Permanent Residence:

Head of Household: \_\_\_\_\_ Village/Town: \_\_\_\_\_ Parish: \_\_\_\_\_  
Country of Residence: \_\_\_\_\_ District: \_\_\_\_\_ Sub-County: \_\_\_\_\_

### Occupation:

Farmer  Butcher  Hunter/trader of game meat  Miner  Religious leader  Housewife  Pupil/student  Child  
 Businessman/woman; type of business: \_\_\_\_\_  Transporter; type of transport: \_\_\_\_\_  
 Healthcare worker; position: \_\_\_\_\_ healthcare facility: \_\_\_\_\_  Traditional/spiritual healer  
 Other; please specify occupation: \_\_\_\_\_

### Location Where Patient Became Ill:

Village/Town: \_\_\_\_\_ District: \_\_\_\_\_ Sub-County: \_\_\_\_\_  
GPS Coordinates at House: latitude: \_\_\_\_\_ longitude: \_\_\_\_\_  
*If different from permanent residence, Dates residing at this location: \_\_\_/\_\_\_/\_\_\_ - \_\_\_/\_\_\_/\_\_\_ (D, M, Yr)*

## Section 2. Clinical Signs and Symptoms

Date of Initial Symptom Onset: \_\_\_/\_\_\_/\_\_\_ (D, M, Yr)

Please tick an answer for **ALL** symptoms indicating if they occurred during **this illness** between symptom onset and case detection:

Fever  Yes  No  Unk

*If yes, Temp: \_\_\_° C Source:  Axillary  Oral  Rectal*

Vomiting/nausea  Yes  No  Unk

Diarrhea  Yes  No  Unk

Intense fatigue/general weakness  Yes  No  Unk

Anorexia/loss of appetite  Yes  No  Unk

Abdominal pain  Yes  No  Unk

Chest pain  Yes  No  Unk

Muscle pain  Yes  No  Unk

Joint pain  Yes  No  Unk

Headache  Yes  No  Unk

Cough  Yes  No  Unk

Difficulty breathing  Yes  No  Unk

Difficulty swallowing  Yes  No  Unk

Sore throat  Yes  No  Unk

Jaundice (yellow eyes/gums/skin)  Yes  No  Unk

Conjunctivitis (red eyes)  Yes  No  Unk

Skin rash  Yes  No  Unk

Hiccups  Yes  No  Unk

Pain behind eyes/sensitive to light  Yes  No  Unk

Coma/unconscious  Yes  No  Unk

Confused or disoriented  Yes  No  Unk

Unexplained bleeding from any site  Yes  No  Unk

### If Yes:

Bleeding of the gums  Yes  No  Unk

Bleeding from injection site  Yes  No  Unk

Nose bleed (epistaxis)  Yes  No  Unk

Bloody or black stools (melena)  Yes  No  Unk

Fresh/red blood in vomit (hematemesis)  Yes  No  Unk

Digested blood/"coffee grounds" in vomit  Yes  No  Unk

Coughing up blood (hemoptysis)  Yes  No  Unk

Bleeding from vagina,  
other than menstruation  Yes  No  Unk

Bruising of the skin  
(petechiae/ecchymosis)  Yes  No  Unk

Blood in urine (hematuria)  Yes  No  Unk

Other hemorrhagic symptoms  Yes  No  Unk

*If yes, please specify: \_\_\_\_\_*

Other non-hemorrhagic clinical symptoms:  Yes  No  Unk

*If yes, please specify: \_\_\_\_\_*

## Section 3. Hospitalization Information

At the time of this case report, is the patient hospitalized or currently being admitted to the hospital?  Yes  No

*If yes, Date of Hospital Admission: \_\_\_/\_\_\_/\_\_\_ (D, M, Yr) Health Facility Name: \_\_\_\_\_*

*Village/Town: \_\_\_\_\_ District: \_\_\_\_\_ Sub-County: \_\_\_\_\_*

Is the patient in isolation or currently being placed there?  Yes  No *If yes, date of isolation: \_\_\_/\_\_\_/\_\_\_ (D, M, Yr)*

Was the patient hospitalized or did he/she visit a health clinic previously **for this illness**?  Yes  No  Unk

*If yes, please complete a line of information for each previous hospitalization:*

Dates of Hospitalization	Health Facility Name	Village	District	Was the patient isolated?
___/___/___ - ___/___/___ (D, M, Yr)				<input type="checkbox"/> Yes <input type="checkbox"/> No
___/___/___ - ___/___/___ (D, M, Yr)				<input type="checkbox"/> Yes <input type="checkbox"/> No

## Section 4. Epidemiological Risk Factors and Exposures

### IN THE PAST ONE(1) MONTH PRIOR TO SYMPTOM ONSET:

1. Did the patient have contact with a known or suspect case, or with any sick person **before** becoming ill?  Yes  No  Unk

*If yes, please complete one line of information for each sick source case:*

Name of Source Case	Relation to Patient	Dates of Exposure (D, M, Yr)	Village	District	Was the person dead or alive ?	Contact Types**
		___/___/___ - ___/___/___			<input type="checkbox"/> Alive <input type="checkbox"/> Dead, date of death: ___/___/___ (D, M, Y)	
		___/___/___ - ___/___/___			<input type="checkbox"/> Alive <input type="checkbox"/> Dead, date of death: ___/___/___ (D, M, Y)	
		___/___/___ - ___/___/___			<input type="checkbox"/> Alive <input type="checkbox"/> Dead, date of death: ___/___/___ (D, M, Y)	

**\*\*Contact Types:**  
(list all that apply)

- 1 – Touched the body fluids of the case (blood, vomit, saliva, urine, feces)
- 2 – Had direct physical contact with the body of the case (alive or dead)
- 3 – Touched or shared the linens, clothes, or dishes/eating utensils of the case
- 4 – Slept, ate, or spent time in the same household or room as the case

2. Did the patient attend a funeral **before** becoming ill?  Yes  No  Unk

*If yes, please complete one line of information for each funeral attended:*

Name of Deceased Person	Relation to Patient	Dates of Funeral Attendance (D, M, Yr)	Village	District	Did the patient participate (carry or touch the body)?
		___/___/___ - ___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No
		___/___/___ - ___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Did the patient travel outside their home or village/town **before** becoming ill?  Yes  No  Unk

*If yes, Village: \_\_\_\_\_ District: \_\_\_\_\_ Date(s): \_\_\_/\_\_\_/\_\_\_ - \_\_\_/\_\_\_/\_\_\_ (D, M, Yr)*

4. Was the patient hospitalized or did he/she go to a clinic or visit anyone in the hospital **before** this illness?  Yes  No  Unk

*If yes, Patient Visited: \_\_\_\_\_ Date(s): \_\_\_/\_\_\_/\_\_\_ - \_\_\_/\_\_\_/\_\_\_ (D, M, Yr)*

*Health Facility Name: \_\_\_\_\_ Village: \_\_\_\_\_ District: \_\_\_\_\_*

5. Did the patient consult a traditional/spiritual healer **before** becoming ill?  Yes  No  Unk

*If yes, Name of Healer: \_\_\_\_\_ Village: \_\_\_\_\_ District: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ (D, M, Yr)*

6. Did the patient have direct contact (hunt, touch, eat) with animals or uncooked meat **before** becoming ill?  Yes  No  Unk

*If yes, please tick all that apply:*

- |  |  |
|--|--|
| <p><b>Animal:</b></p> <p><input type="checkbox"/> Bats or bat feces/urine</p> <p><input type="checkbox"/> Primates (monkeys)</p> <p><input type="checkbox"/> Rodents or rodent feces/urine</p> <p><input type="checkbox"/> Pigs</p> <p><input type="checkbox"/> Chickens or wild birds</p> <p><input type="checkbox"/> Cows, goats, or sheep</p> <p><input type="checkbox"/> Other; <i>specify</i> _____</p> | <p><b>Status (check one only):</b></p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> |
|--|--|

7. Did the patient get bitten by a tick in the past 2 weeks?  Yes  No  Unk

## Section 5. Clinical Specimens and Laboratory Testing

- Specimen/shipping instructions:**
- Label sample with **patient name, date of collection, and case ID**
  - Send sample **cold** with a **cold/ice pack**, and **packaged appropriately**.
  - Collect whole blood in a purple top (EDTA) tube – green or red top tubes acceptable if purple not available
  - Preferred sample volume = 4ml** (minimum sample volume = 2ml)

*Has this patient had a sample submitted previously?*  Yes  No

**Sample 1:**

*Do not complete  
UVRI Only*

Sample Collection Date: \_\_\_/\_\_\_/\_\_\_ (D, M, Yr)

Sample Type:

- Whole Blood  
 Post-mortem heart blood  
 Skin biopsy  
 Other specimen type, specify: \_\_\_\_\_

**Sample 2:**

*Do not complete  
UVRI Only*

Sample Collection Date: \_\_\_/\_\_\_/\_\_\_ (D, M, Yr)

Sample Type:

- Whole Blood  
 Post-mortem heart blood  
 Skin biopsy  
 Other specimen type, specify: \_\_\_\_\_

## Section 6. Case Report Form Completed by:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Position: \_\_\_\_\_ District: \_\_\_\_\_ Health Facility: \_\_\_\_\_

Information provided by:  Patient  Proxy; *If proxy, Name:* \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Case Name:

Outbreak Case ID:

**\*\*If the patient is deceased or has already recovered from illness, please fill out the next section.  
\*\*If the patient is currently admitted to the hospital, leave the next section blank (it will be completed upon discharge)**

### Section 7. Patient Outcome Information

*Please fill out this section at the time of patient recovery and discharge from the hospital OR at the time of patient death.*

Date Outcome Information Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_ (D, M, Yr)

Final Status of the Patient:  Alive  Dead

Did the patient have signs of unexplained bleeding at any time during their illness?  Yes  No  Unk

If yes, please specify: \_\_\_\_\_

**If the patient has recovered and been discharged from the hospital:**

Name of hospital discharged from: \_\_\_\_\_ District: \_\_\_\_\_

If the patient was isolated, Date of discharge from the isolation ward: \_\_\_\_/\_\_\_\_/\_\_\_\_ (D, M, Yr)

Date of discharge from the hospital: \_\_\_\_/\_\_\_\_/\_\_\_\_ (D, M, Yr)

**If the patient is dead:**

Date of Death: \_\_\_\_/\_\_\_\_/\_\_\_\_ (D, M, Yr)

Place of Death:  Community  Hospital: \_\_\_\_\_  Other: \_\_\_\_\_

Village: \_\_\_\_\_ District: \_\_\_\_\_ Sub-County: \_\_\_\_\_

Date of Funeral/Burial: \_\_\_\_/\_\_\_\_/\_\_\_\_ (D, M, Yr) Funeral conducted by:  Family/community  Outbreak burial team

Place of Funeral/Burial:

Village: \_\_\_\_\_ District: \_\_\_\_\_ Sub-County: \_\_\_\_\_

**Please tick an answer for ALL symptoms indicating if they occurred at any time during this illness including during hospitalization:**

Fever  Yes  No  Unk

If yes, Temp: \_\_\_\_° C Source:  Axillary  Oral  Rectal

Vomiting/nausea  Yes  No  Unk

Diarrhea  Yes  No  Unk

Intense fatigue/general weakness  Yes  No  Unk

Anorexia/loss of appetite  Yes  No  Unk

Abdominal pain  Yes  No  Unk

Chest pain  Yes  No  Unk

Muscle pain  Yes  No  Unk

Joint pain  Yes  No  Unk

Headache  Yes  No  Unk

Cough  Yes  No  Unk

Difficulty breathing  Yes  No  Unk

Difficulty swallowing  Yes  No  Unk

Sore throat  Yes  No  Unk

Jaundice (yellow eyes/gums/skin)  Yes  No  Unk

Conjunctivitis (red eyes)  Yes  No  Unk

Skin rash  Yes  No  Unk

Hiccups  Yes  No  Unk

Pain behind eyes/sensitive to light  Yes  No  Unk

Coma/unconscious  Yes  No  Unk

Confused or disoriented  Yes  No  Unk

Other non-hemorrhagic clinical symptoms:  Yes  No  Unk

If yes, please specify: \_\_\_\_\_