OMB Approved
0920-XXXX
Expiration Date

LIBERIA EBOLA CASE INVESTIGATION FORM

Outbreak Case ID: ____________

Date of Case Report: ____/____/_____ (DD, MM, YY)

Section 1. Patient Information

Patient's Last Name: ______________________ **First Name**:__________________________

Age: ______ ☐ Years ☐ Months **Gender:** ☐ Male ☐ Female

Mobile Phone Number: __________________________

Patient Status at Time of This Report: ☐ Alive ☐ Dead *If dead,* Date of Death: ___/___/___ (DD, MM, YY)

Permanent Residence:
Head of Household: _____________________ Village/Town: ____________________ Zone: ________________
Country of Residence: __________________ County: _____________________ District: ___________________

Occupation:
☐ Healthcare worker; position: ____________________ healthcare facility: ______________________
☐ Other; please specify occupation: ________________________

Location Where Patient Became Ill:
Village/Town: ______________________ County: ______________________ District: _____________________

Section 2. Clinical Signs and Symptoms

Date Patient First Became Sick: ____/____/______ (D, M, Yr)

Please mark an answer for ALL symptoms indicating if they occurred during this illness:

Symptom			
Fever	☐ Yes	☐ No	☐ Unk
Vomiting/nausea	☐ Yes	☐ No	☐ Unk
Diarrhea	☐ Yes	☐ No	☐ Unk
Intense fatigue/weakness	☐ Yes	☐ No	☐ Unk
Anorexia/loss of appetite	☐ Yes	☐ No	☐ Unk
Abdominal pain	☐ Yes	☐ No	☐ Unk
Muscle pain	☐ Yes	☐ No	☐ Unk
Joint pain	☐ Yes	☐ No	☐ Unk
Headache	☐ Yes	☐ No	☐ Unk
Difficulty breathing	☐ Yes	☐ No	☐ Unk
Difficulty swallowing	☐ Yes	☐ No	☐ Unk
Hiccups	☐ Yes	☐ No	☐ Unk
Unexplained bleeding	☐ Yes	☐ No	☐ Unk

If yes, please specify: _________________________

Section 3. Hospitalization Information

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

If yes, Date of Hospital Admission: ____/____/_____ (DD, MM, YY)

Hospital Name: _____________________________ County: ______________________

Is the patient now, or will he/she soon be, in an Ebola treatment unit (ETU)? ☐ Yes ☐ No

If yes, date of admission (or future admission) to the ETU (isolation): ____/____/_____ (DD, MM, YY)

Was the patient hospitalized or did he/she visit a clinic previously <u>for this illness</u>? ☐ Yes ☐ No ☐ Unk

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If yes, Dates of Hospitalization: ___/___/____ - ___/___/____(DD, MM, YY)

Hospital/Clinic Name:: __________________ County: _________________

Section 4. Epidemiological Risk Factors and Exposures

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

1. Did the patient have contact with an Ebola case or any sick person in the one month before becoming ill? ☐ Yes ☐ No ☐ Unk

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

Name of Source Case	Date of Last Contact (DD, MM, YY)	Village	County	Was the person dead or alive ?
	___/___/___			☐ Alive ☐ Dead, date of death: ___/___/___ (DD, MM, YY)
	___/___/___			☐ Alive ☐ Dead, date of death: ___/___/___ (DD, MM, YY)

2. Did the patient attend a funeral in the one month before becoming ill? ☐ Yes ☐ No ☐ Unk

If yes, Name of Deceased Person: ___________________ Date of Funeral: (DD, MM, YY): ___/___/____

Village/Town: ____________________________ County: ____________________________

Did the patient participate (carry or touch the body)? ☐ Yes ☐ No

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

If yes, Village: ________________ County: ________________ Date(s): ___/___/___ - ___/___/___ (DD, MM, YY)

Section 6. Case Report Form Completed by:

Name: ___________________________ Phone: ______________________ E-mail: _________________________

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: ____/____/_____ (DD, MM, YY)

Final Status of the Patient: ☐ Alive/Recovered ☐ Dead

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

Hospital discharged from: ____________________County: ___________________

Date of discharge from the hospital: ____/____/______ (DD, MM, YY)

If the patient was isolated in an Ebola treatment unit, Date of discharge from isolation: ____/____/____ (DD, MM, YY)

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If the patient is dead:

Date of Death: ____/____/_____ (DD, MM, YY) Place of Death: ☐ Community ☐ Hospital: ___________________

Date of Funeral/Burial: ___/___/___ (DD, MM, YY) Funeral conducted by: ☐ Family/community ☐ Outbreak burial team

LABORATORY FORM (sample #2)

Outbreak Case ID: [ ]

Patient's Last Name: ______________________ First Name:_____________________________
Age: _______ ☐ Years ☐ Months Gender: ☐ Male ☐ Female

Permanent Residence:
Village/Town: _____________________ County: _____________________ Country of Residence: _________________

Date of Initial Symptom Onset: ____/____/______ (DD, MM, YY)

Patient Status at Time Sample Collected: ☐ Alive ☐ Dead *If dead,* Date of Death: ___/___/____ (DD, MM, YY)

Health Facility Submitting Sample: _____________________ **Person Submitting Sample:** ____________________
Submitter's Phone Number: ________________________ **Submitter's Email:** ______________________________

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

Sample 1: [ ]

Sample Collection Date: ____/____/______ (DD, MM, YY)

Sample Type:
- ☐ Whole Blood
- ☐ Post-mortem heart blood
- ☐ Skin biopsy
- ☐ Saliva swab
- ☐ Other specimen type, specify: ________________

Sample 2: [ ]

Sample Collection Date: ____/____/____ (DD, MM, YY)

Sample Type:
- ☐ Whole Blood
- ☐ Post-mortem heart blood
- ☐ Skin biopsy
- ☐ Saliva swab
- ☐ Other specimen type, specify: ___________

LABORATORY FORM (sample #1)

Outbreak Case ID: [ ]

Patient's Last Name: ______________________ First Name:_____________________________
Age: _______ ☐ Years ☐ Months Gender: ☐ Male ☐ Female

Permanent Residence:
Village/Town: _____________________ County: _____________________ Country of Residence: _________________

Date of Initial Symptom Onset: ____/____/______ (DD, MM, YY)

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Patient Status at Time Sample Collected: ☐ Alive ☐ Dead *If dead,* Date of Death: ___/___/____ (DD, MM, YY)

Health Facility Submitting Sample: ____________________ **Person Submitting Sample:** ___________________
Submitter's Phone Number: _______________________ **Submitter's Email:** ____________________________

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

Sample 1: [ ]

Sample Collection Date: ____/____/______ (DD, MM, YY)

Sample Type:
- ☐ Whole Blood
- ☐ Post-mortem heart blood
- ☐ Skin biopsy
- ☐ Saliva swab
- ☐ Other specimen type, specify: ________________

Sample 2: [ ]

Sample Collection Date: ____/____/____ (DD, MM, YY)

Sample Type:
- ☐ Whole Blood
- ☐ Post-mortem heart blood
- ☐ Skin biopsy
- ☐ Saliva swab
- ☐ Other specimen type, specify: __________

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