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 <u>ALL</u> symptoms indicating if they occurred during <u>this illness</u>:

Fever	☐ Yes	☐ No	☐ Unk	Headache	☐ Yes	☐ No	☐ Unk
Vomiting/nausea	☐ Yes	☐ No	☐ Unk	Difficulty breathing	☐ Yes	☐ No	☐ Unk
Diarrhea	☐ Yes	☐ No	☐ Unk	Difficulty swallowing	☐ Yes	☐ No	☐ Unk
Intense fatigue/weakness	☐ Yes	☐ No	☐ Unk	Hiccups	☐ Yes	☐ No	☐ Unk
Anorexia/loss of appetite	☐ Yes	☐ No	☐ Unk				
Abdominal pain	☐ Yes	☐ No	☐ Unk	**Unexplained bleeding**	☐ Yes	☐ No	☐ Unk
Muscle pain	☐ Yes	☐ No	☐ Unk	*If yes,* please specify: _____			
Joint pain	☐ Yes	☐ No	☐ Unk				

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

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: _____