## LIBERIA EBOLA CASE INVESTIGATION FORM

Outbreak	
Case ID:	

Date of Case Report:/ (DD, MM, YY)					
Section 1.	Patient Info	rmation			
Patient's Last Name: First Name:  Age:					
Patient Status at Time of This Re	port: 🗌 Alive 🗌 Dea	ad If dead, Date of Death:	_// (DD, MM, YY)		
Permanent Residence: Head of Household: Country of Residence:	-				
Occupation:  Healthcare worker; position: healthcare facility:  Other; please specify occupation:					
Location Where Patient Became Village/Town:		District:			
Section 2.	Clinical Signs and	d Symptoms			
Date Patient First Became Sick:		(D, M, Yr)			
Please mark an answer for ALL	symptoms indicating	if they occurred during this	illness:		
Fever Vomiting/nausea Diarrhea Intense fatigue/weakness Anorexia/loss of appetite Abdominal pain Muscle pain Joint pain	Yes No Unk	Headache Difficulty breathing Difficulty swallowing Hiccups  Unexplained bleeding  If yes, please specify:	Yes No Unk Yes No Unk Yes No Unk Yes No Unk Unk Yes No Unk Unk		
Section 3.	Hospitalizatio	n 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 d	lid he/she visit a clin	ic previously <u>for this illness</u>	? 🗌 Yes 🗌 No 🔲 Unk		

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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?	If yes, Dates of Hospitaliz	zation://_	/	/(DD, MM	, YY)	
In the PAST ONE(1) MONTH PRIOR TO SYMPTOM ONSET:	Hospital/Clinic Nar	ne::	Co	ounty:		
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 III?	Section 4.	Epidemiologi	cal Risk Fa	ctors and E	xposures	
ill?	IN THE PAST ONE(1) MO	NTH PRIOR TO SY	YMPTOM ONS	ET:		
ill?	1 Did the nationt have c	ontact with an F	hola case or	any sick ner	son in the one month before becoming	
Name of Source Case   Date of Last   Contact   Contact   Contact   CD, MM, YY)     Alive   Dead, date of death:			bola case of	arry sick per	son in the one month <u>before</u> becoming	
Contact (DD, MM, YY)    Alive   Dead, date of death:	If yes, please complet	e one line of infor	mation for ea	ch sick source	e case:	
	Name of Source Case	Contact	Village	County	Was the person dead or alive?	
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):   J   Did the patient participate (carry or touch the body)?   Yes   No   Unk   If yes, Village/Town:   County:   Did the patient travel outside their home or village/town before becoming ill?   Yes   No   Unk   If yes, Village:   County:   Date(s):   J   - J   (DD, MM, YY)    Section 6.						
2. Did the patient attend a funeral in the one month before becoming ill?					Alive	
Date of Funeral: (DD, MM, YY):/		/			Dead, date of death:/(DD, MM, YY)	
Date of Funeral: (DD, MM, YY):	2 Did the nations attend	a funaral in the	ana manth h	oforo booom	ing ill2	
Village/Town: County: Did the patient participate (carry or touch the body)?						
Did the patient participate (carry or touch the body)?	-					
3. Did the patient travel outside their home or village/town before becoming ill?					<u></u>	
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)	Did the patient	participate (carry	or todorr the i	oody):		
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)	3. Did the patient travel	outside their hor	ne or village	/town <u>before</u>	becoming ill?  Yes  No Unk	
Name:	If yes, Village:	Co	unty:		Date(s):// (DD, MM, YY)	
Name:						
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)	Section 6.	Case R	eport Form	Completed	by:	
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)	Name:	Ph	one:		E-mail:	
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:/	Section 7	Detic	of Outcome	Information		
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)	Section 7.	Patie	nt Outcome	Information	1	
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)	Please fill out this section at the time of patient recovery and discharge from the hospital					
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)	OR at the time of patien	t death.				
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 has recovered and been discharged from the hospital:  Hospital discharged from:County:  Date of discharge from the hospital:/(DD, MM, YY)	Date Outcome Informati	on Completed: _	//	(DD, MM, `	YY)	
Hospital discharged from:County:  Date of discharge from the hospital:/(DD, MM, YY)	Final Status of the Patient:   Alive/Recovered   Dead					
Hospital discharged from:County:  Date of discharge from the hospital:/(DD, MM, YY)						
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 cor	nducted by:   Family/community   Outbreak burial team			
LABORATORY FORM (sample #2)  Patient's Last Name: First Name: Age: Years  Months Gender:  Male  F  Permanent Residence:  Village/Town: County:	Female			
Date of Initial Symptom Onset:/(DD, M				
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 Email: Submitter's Email:				
Has this patient had a sample submitted province V2 V2				
Has this patient had a sample submitted previously? ☐ Yes ☐	INO			
Sample 1:	Sample 2:			
Sample Collection Date:/ (DD, MM, YY)	Sample Collection Date:/ (DD, MM, YY)			
Sample Type:  Whole Blood Post-mortem heart blood Skin biopsy Saliva swab Other specimen type, specify:	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 F	Female			
Permanent Residence:				
Village/Town: County:	Country of Residence:			
Date of Initial Symptom Onset:/ (DD, M	M, 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 previous	<i>ly?</i> ☐ Yes ☐ No
Sample 1:	Sample 2:
Sample Collection Date:/ (DD,	MM, YY) Sample Collection Date:/(DD, MM, YY)
Sample Type:	Sample Type:
☐ Whole Blood	☐ Whole Blood
Post-mortem heart blood	Post-mortem heart blood
Skin biopsy	Skin biopsy
☐ Saliva swab	☐ Saliva swab
Other specimen type, specify:	Other specimen type, specify: