

VIRAL HEMORRHAGIC FEVER CONTACT LISTING FORM

Case Information									
Case ID	Surname	Other Names	Head of Household	Village	District	County	Date of Symptom Onset	Date of Admission to Isolation	Date of Death

****For all information on location, please list information on where the contact will be residing for the next month.**

Contact Information													
Surname	Other Names	Sex (M/F)	Age (yrs)	Relation to Case	Date of Last Contact with Case	Type of Contact (1,2,3,4)* <u>list all</u>	Head of Household	Village	Zone	County	Village Leader	Phone Number	Healthcare Worker (Y/N) <i>If yes, what facility?</i>

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-XXXX.

OMB Approved
0920-XXXX
Expiration Date: XX/XX/XXXX

***Types of Contact:**

- 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

Contact Sheet Filled by: Name: _____ Position: _____ Phone: _____