Form Approved

OMB No. 0920-XXXX

Exp. Date XX/XX/20XX

**Person Under Investigation (PUI) for Ebola Form – United States**

State/Local ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CDC ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Instructions: Please complete the following form for each person under investigation for Ebola virus disease. If the person tests positive for Ebola, please use theplease use information gathered from this form to populate the Ebola Virus Disease Case Investigation Form – United States form (Form 1).

Public reporting burden of this collection of information is estimated to average 10 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

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| 1. **Patient Information** | | |
| Date of form completed : MM / DD / YYYY Date PUI identified: MM / DD / YYYY  **Form Administrator**  Name (Last, First): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Patient Information**  Patient Name (Last, First): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male Female  Date of birth: MM / DD / YYYY Age Group: Adult Pediatric (<18 years) Age: \_\_\_\_\_\_\_\_\_  Citizenship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country of Residence: U.S. Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Number of household contacts: \_\_\_\_\_\_\_\_  **Patient Hospitalization** Is the patient currently admitted to a hospital? Yes No Date of admission: MM / DD / YY  Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_  Physician Name (Last, First): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is the patient being treated under isolation precautions? Yes No Date of isolation: MM / DD / YY  Was the patient transferred from a previous health care facility? Yes No  Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ | | |
| 1. **Medical History and Symptom Onset** | | **III. Epidemiologic Risk Factors** |
| Medical History: | | 1. Have you had contact with a suspect or known case of  Ebola in the 3 weeks before you became ill?  Yes No Unknown  If yes, name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State/Local ID: \_\_\_\_\_\_\_\_\_\_ CDC ID: \_\_\_\_\_\_\_\_  If yes, please describe:  2. Did you travel outside the United States in the 3 weeks before becoming ill? Yes No  Country (1) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MM / DD / YYYY to MM / DD / YYYY  Country (2) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MM / DD / YYYY to MM / DD / YYYY  3. Did you provide health care for any known/ suspect cases of Ebola? Yes No  If yes, please describe: |
| **Have you experienced any of the following symptoms?** | **If yes, date symptom began**  (\_\_\_/\_\_\_/\_\_\_\_) |
| Fatigue |  |
| Fever/Feverish Temp:\_\_\_\_\_ |  |
| Headache |  |
| Stomach pain |  |
| Muscle pain |  |
| Diarrhea |  |
| Unexplained bruising/bleeding |  |
| Vomiting |  |
| Other: |  |

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| **IV. Laboratory Testing** |
| **Test 1**  Originating Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_  Point of Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Where was testing performed? LRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CDC  Specimen ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Test Performed (PCR, BioFire Defense FilmArray): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test Date: MM / DD / YYYY  Result: Positive Negative Inconclusive Result Date: MM / DD / YYYY |
| **Test 2**  Originating Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_  Point of Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Where was testing performed? LRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CDC  Specimen ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Test Performed (PCR, BioFire Defense FilmArray): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test Date: MM / DD / YYYY  Result: Positive Negative Inconclusive Result Date: MM / DD / YYYY |
| **Test 3**  Originating Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_  Point of Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Where was testing performed? LRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CDC  Specimen ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Test Performed (PCR, BioFire Defense FilmArray): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test Date: MM / DD / YYYY  Result: Positive Negative Inconclusive Result Date: MM / DD / YYYY |
| **Test 4**  Originating Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_  Point of Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Where was testing performed? LRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CDC  Specimen ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Test Performed (PCR, BioFire Defense FilmArray): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test Date: MM / DD / YYYY  Result: Positive Negative Inconclusive Result Date: MM / DD / YYYY |