

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 the information gathered from this form to populate the Ebola Virus Disease Case Investigation Form – United States form (Form 1).

DRAFT

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).

Ebola Virus Disease - Person Under Investigation (PUI) Form

I. 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: _____																					
II. 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:																				
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%; padding: 5px;">Have you experienced any of the following symptoms?</th> <th style="width: 30%; padding: 5px;">If yes, date symptom began (/ /)</th> </tr> </thead> <tbody> <tr><td style="padding: 5px;">• Fatigue</td><td></td></tr> <tr><td style="padding: 5px;">• Fever/Feverish Temp: _____</td><td></td></tr> <tr><td style="padding: 5px;">• Headache</td><td></td></tr> <tr><td style="padding: 5px;">• Stomach pain</td><td></td></tr> <tr><td style="padding: 5px;">• Muscle pain</td><td></td></tr> <tr><td style="padding: 5px;">• Diarrhea</td><td></td></tr> <tr><td style="padding: 5px;">• Unexplained bruising/bleeding</td><td></td></tr> <tr><td style="padding: 5px;">• Vomiting</td><td></td></tr> <tr><td style="padding: 5px;">• Other:</td><td></td></tr> </tbody> </table>	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:		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 (/ /)																				
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• Other:																					

Ebola Virus Disease - Person Under Investigation (PUI) Form

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