

## Ebola Virus Disease Case Investigation Form – United States

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

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

Instructions: Please complete the following form for each confirmed Ebola virus disease (Ebola) case. Use the “Notes” portion of each section to record additional information regarding potential exposures or contacts or other information that may aid the investigation that is not already captured on the form. If the case was listed as a contact, please use information gathered from the *Ebola Virus Disease Contact Tracing Form* or other applicable questionnaires to populate this form *BEFORE* the case patient interview.

Public reporting burden of this collection of information is estimated to average 30 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).

**I. Interview Information**

Date of form completed : / /

Date case identified: / /

**Interviewer Information**

Interviewer Name (Last, First): \_\_\_\_\_

State/Local Health Department (HD): \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email address: \_\_\_\_\_

**How was the case identified? (Check all that apply)**

- DHS Airport Risk Assessment

Date of Airport Assessment: / / Airport Code: \_\_\_\_\_

- Active Monitoring via State/ Local HD Name of HD: \_\_\_\_\_

If yes, why? • Return from an affected country • Contact with a suspect/known case of Ebola

- Emergency Room/Hospital/Outpatient Clinic Facility Name: \_\_\_\_\_

- Other Specify: \_\_\_\_\_

**Informant Information**

Who is providing information for this form?

- Patient

- Other Name (Last, First): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Reason patient unable to provide information:

- No access because of isolation • Patient deceased • Patient too ill to be interviewed

- Other: \_\_\_\_\_

Was this form administered via a translator?  Yes  No

If yes, in which language was this form administered? \_\_\_\_\_

Translator Name (Last, First): \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail address: \_\_\_\_\_

**Notes:**

**II. Ebola Patient Demographic and Contact Information**

Patient Name (Last, First): \_\_\_\_\_

Sex: • Male • Female

Date of birth: / / Age: \_\_\_\_\_

Citizenship: \_\_\_\_\_

Country of Residence: • United States of America • Other (specify): \_\_\_\_\_

Contact Information (for country of residence as indicated above)

U.S. Residence

Home Street Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Non-U.S. Residence

Home Street Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City/Village: \_\_\_\_\_ State/County/District/Prefecture: \_\_\_\_\_

Occupational Information

Occupation: \_\_\_\_\_ Name of Business/Organization: \_\_\_\_\_

Supervisor Name (Last, First): \_\_\_\_\_

Supervisor Phone Number: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Business Address: \_\_\_\_\_ Suite. # \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Notes:

III. Hospitalization and Laboratory Information

Patient Hospitalization

At the time of this interview, is the patient hospitalized? • Yes • No

If yes, date of admission: / / Patient ID: \_\_\_\_\_

Facility Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Physician Name (Last, First): \_\_\_\_\_ Contact Information: \_\_\_\_\_

At the time of this interview, is the patient being treated under isolation precautions? • Yes • No

If yes, date of isolation: / /

**Did the patient previously seek health care for this illness?** • Yes • No • Unknown

*If prior hospitalization information is unknown, Section IV (Medical History, page 5) allows for the collection of this information.*

Date(s) of visit	Facility Name	City	State	Was the patient isolated?
				• Yes • No • Unknown
				• Yes • No • Unknown
				• Yes • No • Unknown

**Laboratory Testing**

Collection date (MM/DD/YYYY)	Location of Test	Test Performed (e.g. PCR, BioFire Defense FilmArray)	Test date (MM/DD/YYYY)	Result
	• LRN • CDC			• Positive • Negative • Inconclusive
	• LRN • CDC			• Positive • Negative • Inconclusive
	• LRN • CDC			• Positive • Negative • Inconclusive
	• LRN • CDC			• Positive • Negative • Inconclusive

**Notes:**

**IV. Medical History**

**Did you previously seek health care for this illness?** • Yes • No

Date(s) of visit	Facility Name	City	State

**Do you have any known medical conditions?** • Yes • No

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

State/Local ID:

CDC ID:

*If the patient is female.* Are you pregnant? • Yes • No • Unknown

Do you take any medications for your medical conditions? • Yes • No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**V. Symptom Onset Information**

When did you first begin to feel any symptoms, including fatigue or generally not feeling well?

Date of onset:    /    /            Refer to the patient's answer as [Date of Onset]

*Please see the Symptom Onset Table on Page 6.*

*Use the information collected in the following question to populate the Symptom Onset Table.*

Please describe the course of your illness from [Date of Onset] until the day you were admitted to the hospital:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe the course of your illness from [Date of Onset] until the day you were admitted to the hospital.  
*Continued on Page 6.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Continued from page 5.

\_\_\_\_\_  
\_\_\_\_\_

---



---

Since [date of onset], which of the following have you experienced?	If yes, date symptom began (__/__/__)	Is this symptom unusual for you to experience?*	Did the symptom become more severe?
• Fatigue		• Yes • No	• Yes • No
• Fever/Felt feverish Temp:_____		• Yes • No	• Yes • No If yes, Date: __/__/____ Temp:_____
• Headache		• Yes • No	• Yes • No
• Stomach Pain		• Yes • No	• Yes • No
• Muscle Pain		• Yes • No	• Yes • No
• Diarrhea		• Yes • No	• Yes • No
• Unexplained Bruising/Bleeding		• Yes • No	• Yes • No
• Vomiting		• Yes • No	• Yes • No
• Other		• Yes • No	• Yes • No
• Other		• Yes • No	• Yes • No

\*Example: Recent headache would not be unusual for a patient with chronic migraines

**VI. Activity Log from Date of Onset**

*Use the following guiding questions to describe the patient's whereabouts and activities for each day*

State/Local ID:

CDC ID:

***between date of onset and hospitalization:*** What did you do on the day that you first felt any symptoms? Did you go to work/school? How did you get there? Who did you interact with? Did you engage in any physical activity or group sports? Did you attend any community or organizational meetings? Did you eat out at any restaurants? Did you partake in any social activities? (use additional sheets of paper if necessary)

Date of Onset: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

/ / : \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

/ / : \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Hospitalization: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Please use the above notes to begin populating pages 9 and 10: (1) Log of Activities from Date of Onset to Hospitalization and (2) List of Community Contacts Since Date of Onset.***

**\*Guidance for Interviewer on Defining Contacts**

**Ebola Virus Disease Case Investigation Form – United States**

State/Local ID:

CDC ID:

Type of Contact	Description	Examples
Casual Contact	Brief interactions with a symptomatic suspect/known case of Ebola.	Walking by the case patient; being in the same room for a very short period of time.
Close Contact	Within approximately 3 feet of a symptomatic suspect/known case of Ebola for a prolonged period of time (at least one hour) without wearing appropriate Personal Protective Equipment (PPE).	Riding in a vehicle with the case patient for more than one hour; Sitting next to the case patient during a three-hour business meeting.
Direct Contact	Directly touching a symptomatic suspect/known case of Ebola OR the blood or body fluids of a symptomatic suspect/known case of Ebola.	Shaking hands; Giving a hug.

***Please ensure that both domestic and international contacts are listed.***



**List of Community Contacts\* Since Date of Onset**

**Use the following as probing questions to supplement the initial list of contacts generated:** Is there anyone else you may have interacted with at [Restaurant X]? Did you meet with any business partners/colleagues that you do not normally interact with? Did you interact with anyone at your child’s school (teacher, classmates, other parents, etc.)?

No	First name	Last name	Sex	Relation to case	Last contact date	Street address	City	State	Phone	Description of interaction
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

\* See page 8 for Guidance for Interviewer on Defining Contacts.

State/Local ID:

CDC ID:

**List of Community Contacts\* Since Date of Onset**

**Use the following as probing questions to supplement the initial list of contacts generated:** Is there anyone else you may have interacted with at [Restaurant X]? Did you meet with any business partners/colleagues that you do not normally interact with? Did you interact with anyone at your child’s school (teacher, classmates, other parents, etc.)?

No	First name	Last name	Sex	Relation to case	Last contact date	Street address	City	State	Phone	Description of interaction
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										

\* See page 8 for Guidance for Interviewer on Defining Contacts.

**VII. Animal Contact Information**

Since [date of onset], have you had any contact with any animals (pets, wildlife, livestock, or other animals), either at your home or away from your home, including work?

- Yes
- No
- Unknown

If yes, please provide details:

Animal species	Number of animals	Where located

**Notes:**

If the case was previously listed as a contact, please use information gathered from the "Ebola Virus Disease Contact Tracing Form" to populate the following fields BEFORE the case patient interview.

**VIII. Domestic Epidemiological Risk Factors and Exposures** In the 3 weeks before becoming ill, did you have contact with a known case of Ebola or someone being investigated for Ebola OR the blood or body fluids of a known case of Ebola or someone being investigated for Ebola?

- Yes (Complete this section) • No (Skip to Page 16, Section IX)

1. In the three weeks before becoming ill, did you come in contact with a suspect/known case of Ebola OR the blood or body fluids of a suspect/known case of Ebola outside of a health care setting?

- Yes (Complete Part A) • No

2. Do you work in a health care setting and, in the three weeks before becoming ill, come in contact with a suspect/known case of Ebola OR the blood or body fluids of a suspect/known case of Ebola through your work? • Yes • No

If yes, which of the following best describes your occupation?

- Health Care Worker (Complete Part B) • Laboratory Worker (Complete Part C) • Environmental Decontamination/Cleaning Staff (Complete Part D)

**A. Domestic Community Contact with a Suspect/Known Case of Ebola**

1. Please provide the name of the suspect/known Ebola case with whom you had contact.

(Last, First): \_\_\_\_\_

Please list each date of contact and provide a description: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Did you have any casual contact with a suspect/known case of Ebola (brief interaction, such as walking by him/her or being in the same room for a very short period of time) in which you did not directly touch him or her? • Yes • No • Unknown List each date of contact: \_\_\_\_\_

3. Did you have contact with blood or body fluids from a suspect/known case of Ebola while he/she was ill (including contaminated objects or surfaces such as bedding or clothing)?

- Yes • No • Unknown

If yes, list each date of contact: \_\_\_\_\_

If yes, what body fluids were you in contact with? Check all that apply. • Blood • Feces • Vomit

• Urine • Sweat • Tears • Saliva • Respiratory secretions (e.g. sputum, nasal mucus)

• Semen or vaginal fluids ? Other: \_\_\_\_\_

4. Were you within approximately 3 feet of a suspect/known case of Ebola or within his/her room or care area for a prolonged period of time (at least one hour) while he/she is ill? • Yes • No • Unknown  
If yes, list each date of contact: \_\_\_\_\_
5. Did you share a bathroom or use the same tub or toilet as a known/suspect case of Ebola while he/she was ill? • Yes • No • Unknown  
If yes, list each date of contact: \_\_\_\_\_
6. Did you perform any caregiving activities or household assistance for a suspect/known case of Ebola (helping to bathe or feed the case; washing clothes or dishes)? • Yes • No • Unknown  
If yes, list each date of contact: \_\_\_\_\_
7. Did you share transport with a suspect/known case of Ebola (car, bus, plane, taxi, etc.)?  
•Yes •No • Unknown  
If yes, please provide for **all** shared transport: Date of Travel: / /  
Name of airline and flight number: \_\_\_\_\_  
Origin: \_\_\_\_\_ Destination: \_\_\_\_\_  
Transit Points: \_\_\_\_\_

**Notes:**

**B. Domestic Health Care Worker Exposure**

1. Specific healthcare-associated job: • Doctor • Nurse • Clinical Assistant/Technician • Volunteer  
• Administrative Position • Other: \_\_\_\_\_
2. Please provide the name of the suspect/known Ebola case with whom you had contact.  
(Last, First): \_\_\_\_\_  
Please list each date of contact and provide a description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Did you have any casual contact with a suspect/known case of Ebola (brief interaction, such as walking by him/her or being in the same room for a very short period of time) in which you did not directly touch him or her? • Yes • No • Unknown  
If yes, list each date of contact: \_\_\_\_\_
4. Did you have contact with blood or body fluids from a suspect/known case of Ebola while he/she was ill (including contaminated objects or surfaces such as bedding or clothing), including while you were wearing PPE? • Yes • No • Unknown  
If yes, list each date of contact: \_\_\_\_\_

If yes, what body fluids were you in contact with? *Check all that apply.* • Blood • Feces • Vomit  
• Urine • Sweat • Tears • Saliva • Respiratory secretions (e.g. sputum, nasal mucus)  
• Semen or vaginal fluids • Other: \_\_\_\_\_

If yes, what PPE was worn on these occasions? *Check all that apply.* • None • Gown (impermeable)  
• Facemask • N95 mask or other respirator • Eye protection (goggles or face shield) • Body Suit  
• Gloves • Other: \_\_\_\_\_

5. Were you within approximately 3 feet of a suspect/known case of Ebola or within his/her room or care area for a prolonged period of time (at least one hour)?  Yes  No  Unknown

If yes, list each date of contact: \_\_\_\_\_

If yes, what PPE was worn on these occasions? *Check all that apply.* • None • Gown (impermeable)  
• Facemask • N95 mask or other respirator • Eye protection (goggles or face shield) • Body Suit  
• Gloves • Other: \_\_\_\_\_

6. Did you have any direct contact with a suspect/known case of Ebola (e.g. shaking hands) no matter how brief, including while you were wearing PPE? • Yes • No • Unknown

If yes, list each date of contact: \_\_\_\_\_

If yes, what PPE was worn on these occasions? *Check all that apply.* • None • Gown (impermeable)  
• Facemask • N95 mask or other respirator • Eye protection (goggles or face shield) • Body Suit  
• Gloves • Other: \_\_\_\_\_

**Please provide additional information, particularly on any possible blood/body fluid exposure:**

**C. Domestic Laboratory Worker Exposure**

1. Please list all dates of blood/body fluid exposure: \_\_\_\_\_

2. What body fluids were you in contact with? *Check all that apply.*  Blood  Urine

Other: \_\_\_\_\_

3. What PPE was worn on these occasions? *Check all that apply.* • None • Gown (impermeable)

• Facemask • N95 mask or other respirator • Eye protection (goggles or face shield) • Body Suit  
• Gloves • Other: \_\_\_\_\_

**Please provide additional information, particularly on any possible blood/body fluid exposure:**

**D. Domestic Environmental Exposure**

1. Please list all dates of blood/body fluid exposure: \_\_\_\_\_
2. Which aspects of the patient care environment did you clean or decontaminate? *Check all that apply.*
  - General room or area (including floors, walls, furniture)
  - Linens (including patient clothing, sheets, pillows, towels)
  - Patient care equipment (including bedside commode, IV or urinary catheter tubing, intubation equipment)
  - Other (specify): \_\_\_\_\_
3. What body fluids were you in contact with? *Check all that apply.*
 Blood     Feces     Vomit  
 Urine     Sweat     Tears     Respiratory secretions (e.g. sputum, nasal mucus)     Saliva  
 Semen or vaginal fluids     Other: \_\_\_\_\_
4. What PPE was worn on these occasions? *Check all that apply.*
  - None    • Gown (impermeable)
  - Facemask    • N95 mask or other respirator    • Eye protection (goggles or face shield)    • Body Suit
  - Gloves    • Other: \_\_\_\_\_

**Please provide additional information, particularly on any possible blood/body fluid exposure:**

**IX. International Epidemiological Risk Factors and Exposures** In the three weeks before becoming ill, did you travel to an Ebola-affected country?    • Yes (Complete this section)    • No (Skip to Section X)

**A. International Travel History**

1. Which countries did you travel to outside of the United States in the 3 weeks before becoming ill?
 

Country: _____	Dates:    /    /    to    /    /
Country: _____	Dates:    /    /    to    /    /
Country: _____	Dates:    /    /    to    /    /
2. What was your reason for traveling?    • Country of Residence    • Business    • Humanitarian Work  
 • Visiting Family/Friends    • Tourism    • Other: \_\_\_\_\_
3. What is your reason for traveling to the United States?    • Country of Residence    • Business    • Tourism    •

**Ebola Virus Disease Case Investigation Form – United States**

State/Local ID:

CDC ID:

Immigration • Visiting Family/Friends • Other: \_\_\_\_\_

4. Transit Points: \_\_\_\_\_

5. When did you return to the United States?    /    /

6. While in [Ebola-affected country], did you come in contact with a suspect/known case of Ebola OR the blood or body fluids of a suspect/known case of Ebola in a non-healthcare setting?

• Yes (Complete Part B) • No

7. While in [Ebola-affected country], did you provide health care for a suspect/known case of Ebola?

• Yes (Complete Part C) • No

8. While in [Ebola-affected country], did you process blood/body fluids of a suspect/known case of Ebola in a laboratory setting?

• Yes (Complete Part D) • No

9. While in [Ebola-affected country], did you have direct contact (hunt, touch, eat) with animals or uncooked meat before becoming ill?

• Yes (Complete Part E) • No

**Notes:**

**B. International Contact with a Suspect/Known Case of Ebola**

1. Name of suspect/known case of Ebola (Last, First): \_\_\_\_\_ Relationship: \_\_\_\_\_

Please list each date of contact: \_\_\_\_\_



2. Did you have any casual contact with a suspect/known case of Ebola (brief interaction, such as walking by him/her or being in the same room for a very short period of time) in which you did not directly touch him or her?      • Yes   • No   • Unknown

3. Did you have contact with blood or body fluids from a suspect/known case of Ebola while he/she was ill (including contaminated objects or surfaces such as bedding or clothing)?  
 • Yes   • No   • Unknown  
 If yes, list each date of contact: \_\_\_\_\_

4. Were you within approximately 3 feet of a suspect/known case of Ebola or within his/her room or care area for a prolonged period of time (at least one hour)?   Yes   No   Unknown  
 If yes, list each date of contact: \_\_\_\_\_

5. Did you have any direct contact with a suspect/known case of Ebola (e.g. shaking hands) no matter how brief?   Yes   No   Unknown  
 If yes, list each date of contact: \_\_\_\_\_

6. Did you share a bathroom or use the same tub or toilet as a known/suspect case of Ebola while he/she was ill?   • Yes   • No   • Unknown  
 If yes, list each date of contact: \_\_\_\_\_

7. Did you perform any caregiving activities or household assistance for a suspect/known case of Ebola (helping to bathe or feed the case; washing clothes or dishes)?   • Yes   • No   • Unknown  
 If yes, list each date of contact: \_\_\_\_\_

8. Did you directly handle dead bodies in [Ebola-affected country]? This might include participating in funeral or burial rites or any other activities that involved handling dead bodies.   • Yes   • No   • Unknown

*If yes, please fill out the following table:*

Name of Deceased	Relation to Case	Dates of Funeral Attendance	Location (City, State)

9. Did you share transport with a suspect/known case of Ebola (car, bus, plane, taxi, etc.)?  
 • Yes   • No   • Unknown  
 If yes, please provide for **all** shared transport: Date of Travel:   /   /  
 Name of airline and flight number: \_\_\_\_\_

Origin: \_\_\_\_\_ Destination: \_\_\_\_\_

Transit Points: \_\_\_\_\_

10. Did you ride in a vehicle that may have been used to transport a suspect/known case of Ebola?

- Yes
- No
- Unknown

Notes:

**C. International Health Care Worker Exposure**

1. Specific healthcare-associated job: • Doctor • Nurse • Clinical Assistant/Technician • Cleaning Staff

• Administrative Position • Volunteer • Other: \_\_\_\_\_

2. Were you associated with any humanitarian organizations/agencies in the country? • Yes • No

Name of organization: \_\_\_\_\_

Healthcare Facility Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Village/City: \_\_\_\_\_ Prefecture/District/County: \_\_\_\_\_

3. Please describe your clinical duties: \_\_\_\_\_  
\_\_\_\_\_

4. What kind of PPE did you use? *Check all that apply.* • None • Gown (impermeable) • Facemask

• N95 mask or other respirator • Eye protection (goggles or face shield) • Body Suit • Gloves

• Other: \_\_\_\_\_

5. Did any breaches in PPE take place? • Yes • No • Unknown

If yes, describe: \_\_\_\_\_

6. Last date(s) of contact with a symptomatic known/suspect case of Ebola: / /

**Please provide additional information, particularly on any possible blood/body fluid exposure:**

**D. International Laboratory Worker Exposure**

1. Last date of blood/body fluid exposure: / /

2. What body fluids were you in contact with? *Check all that apply.* ☐ Blood ☐ Urine

☐ Other: \_\_\_\_\_

3. What kind of PPE did you use? *Check all that apply.* • None • Gown (impermeable) • Facemask

- N95 mask or other respirator
- Eye protection (goggles or face shield)
- Body Suit
- Gloves
- Other: \_\_\_\_\_

Please provide additional information, particularly on any possible blood/body fluid exposure:

**E. International Zoonotic Exposure**

Animal or source of meat: \_\_\_\_\_

Type of contact *Check all that apply.* • Hunt • Touch • Eat • Other: \_\_\_\_\_

**X. 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:    /    /                      Final status of patient: • Alive • Deceased

**If the patient has recovered and been discharged from the hospital:**

Facility name at discharge: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Date of isolation discharge (if applicable):    /    /

**If the patient is deceased:**

Date of Death:    /    /                      City: \_\_\_\_\_ State: \_\_\_\_\_

**Was an autopsy or other medical examination performed on the body?** • Yes • No • Unknown

Date of autopsy/medical examination:    /    /

**What was the final disposition of the body?** • Cremation • Burial

**If cremated:** Date of cremation:    /    /

Cremation facility: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

**Ebola Virus Disease Case Investigation Form – United States**

State/Local ID:

CDC ID:

Crematorium Point of Contact: \_\_\_\_\_ Contact Information : \_\_\_\_\_

**If buried:** Date of funeral/ burial:    /    /

Was the body prepared for burial (*washed, embalmed, dressed, etc.*)? • Yes      • No      • Unknown

Who prepared the body for burial? • Funeral home/Mortuary • Family/Friends • Religious community

Funeral home name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Funeral Home Point of Contact: \_\_\_\_\_ Contact Information : \_\_\_\_\_

Place of burial: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

***Please ensure that all individuals who touched or handled the body of an Ebola case are added to the List of Occupational Contacts of a Confirmed Ebola Virus Disease Case (page 21).***



**Ebola Viral Disease Case Investigation Form – United States**

State/Local ID:

CDC ID:

**List of Occupational Contacts\* of a Confirmed Ebola Virus Disease Case (e.g. Health care Workers, Laboratory Workers, Funeral Home Staff)**

<b>No</b>	<b>First name</b>	<b>Last name</b>	<b>Sex</b>	<b>Occupation</b>	<b>Affiliation</b>	<b>Street address</b>	<b>City</b>	<b>State</b>	<b>Phone</b>	<b>Description of interaction</b>
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

*\* See page 8 for Guidance for Interviewer on Defining Contacts.*