OMB Approved
0920-XXXX
Expiration Date xx/xx/xxxx

Health Facility Name: ___________________ Initials of Interviewer: ___________________

Health Facility Assessment and Case Finding Survey

Instructions: Ask to interview the supervising health care worker present at the time of your visit.
My name is ______and I am here on behalf of the [Ministry of Health]. We are working to understand the capacity and needs of health care facilities related to the Ebola response. I will be asking you a few questions about your health facility, as well as the details of any suspect, probable, or confirmed Ebola cases seen at your facility in the last three weeks. The interview should take about 30 minutes, and you are free to skip any questions you do not know the answer to. Do you have any questions?

Date of interview:			

Day XX Mon XXX Year XX

Geographic information for the health facility
County / District / Prefecture:________________________

Community / Village / Zone:___________________________

Other geographic information:__________________________

FACILITY INFORMATION

Name of HCW being interviewed: ______________________________ Phone number: __________________

HCW position:____

Approximate number of medical staff (nurses, doctors, etc):__________________

Approximate number of non-medical staff (cleaners, security, etc):________________

Approximate number of beds (if inpatient hospital):_____________________

Approximate number of visits per month (if outpatient clinic):____________________

Approximate number of admissions per month (if inpatient ward): ___________________

Training
When was the most recent Ebola-specific training at your facility? _____________________

Who provided this training? ____

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 Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-XXXX.

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FACILITY EBOLA RESPONSE PLAN

If an acutely ill patient presented to your facility today and your staff had high concern for Ebola infection, what would be your facility's procedure? I'm going to ask some specific questions:

Who would you call to report the case? (be specific; HCW can give multiple answers)

____

Where would you place the patient in your facility? (be specific)

____

In your opinion, would the staff here have adequate PPE available?
Yes___ No____ If no: what is lacking?:____

In your opinion, does your staff have adequate training to use that PPE appropriately?
Yes___ No_____ If no: what is lacking?:____

In your opinion, does your clinic have adequate materials for disinfection and cleaning?
Yes___ No_____ If no, what is lacking?: ____

Would someone from your facility collect a lab sample on the patient?
Yes______ If yes, did that person have Ebola-specific training? Yes ______ No_______
No ______ If no, how would a lab sample be collected?____________________________________

Would you transfer the patient to another facility?
Yes, as soon as it can be arranged_____
Yes, if a positive test result is received________
No_______
Other:____

If you would transfer the patient, to where/which facility?:___________________________

Supplies

Has your facility received additional PPE for treating potential Ebola patients? Yes_____ No_____

If yes, from whom:___________________________

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Can you demonstrate how you would prepare to dress and undress to see a patient suspected of having Ebola? (*describe demonstration*)

Right now, does your facility have available:

Gloves	Yes	No		Thermometer that can be used on a single suspect Ebola case-patient then discarded	Yes	No
Disposable gowns	Yes	No		Stethoscope that can be used on a single suspect Ebola case-patient then discarded	Yes	No
Respirators/masks	Yes	No		IV fluids and tubing	Yes	No
Face shields or goggles (eye protection)	Yes	No		Chlorine	Yes	No
Boots or foot protection	Yes	No		20 L buckets	Yes	No
Single use gowns	Yes	No		Rubber boots	Yes	No
Plastic apron	Yes	No		Disposable mask	Yes	No
Goggles	Yes	No		Head cover	Yes	No
Plastic garbage bags	Yes	No		Plastic basin for hand washing after consultation	Yes	No
Body bag	Yes	No		Case definitions posted	Yes	No
Chlorine sprayer of 1 litre capacity	Yes	No		Information and sensitization material	Yes	No
Sponge	Yes	No		Sharps box (or modified drug pot)	Yes	No
Formula for preparation of chlorine solution written or described	Yes	No				

Data and Communication

Does your facility have a computer available? Yes_____ No_____

Does your facility have internet access available? Yes_____ No_______

Is your facility in an area that generally has good cell phone reception? Yes_______ No____________

EBOLA CASES AT FACILITY

Has this facility seen any suspect, probable, or confirmed cases of Ebola in the last three weeks? *(use a calendar to define the time frame for the HCW)*
Yes:_____
No:_____ →If no, skip to the next page

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Health Facility Name: ___________________ Initials of Interviewer: ___________________

Patient's Name: __________________________
Origin: Community / Village / Zone : ____________________ County / District / Prefecture:___________________

DOB :				Age:		Gender:	M	F

(*Day XX Mon XXX Year XX)* *(years)*

Date of symptom onset:				Date of presentation to the Health Facility:			

(*Day XX Mon XXX Year XX)* (*Day XX Mon XXX Year XX)*

Date case reported to Ministry:				Method of reporting case/who did you call:	

(*Day XX Mon XXX Year XX)*

Lab results (circle one):	Positive	Negative	No lab sample obtained*	Lab sample obtained, but no results reported
*If no lab sample obtained why not?				
Method of receiving lab results (circle all that apply):	Received call	Received email	Receive text	Receive written report

Patient outcome:

Admitted:	Yes	No	If yes, where:_______________________
Transferred :	Yes	No	If yes, where:_________________AND Who transferred the patient: ______________
Died:	Yes	No	If yes, date of death:________ AND date of burial:______________
			If yes died, who conducted the burial? _______________________
Other:	(*explain*):____		

Any contact tracing conducted for this case (that you are aware of):	Yes	No	Unknown	

Comments:

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