[NAME OF COUNTRY] VIRAL HEMORRHAGIC FEVER CASE INVESTIGATION FORM (SHORT VERSION)

Form Approved OMB Control No. 0920-xxxx Expiration Date xx/xx/xxxx

		Outbreak				
		Case ID:				
Date of Case Report:/	/ (D, M, Yr)					
Section 1.	Patient Info	rmation				
Patient's Surname:	Other Names:					
Age: Years Mont						
Phone Number of Patient/Famil						
Thome ramber of radicity and	y McMbcr					
Status of Patient at Time of This	s Case Report: Aliv	ve Dead If dead, Date of Dea	ath: / / (D, M, Yr)			
	• —	,				
Permanent Residence:	Country ii	District				
Head of Household :						
Sub-County:	Parish:	village/Town:				
Occupation:						
Healthcare worker; position:		healthcare facility:				
Other; please specify occupati						
other, piease speemy occupan	OH					
Location Where Patient Became	e III. Country:					
District:	Sub-County:	 Village/To	wn:			
Section 2.	Clinical Signs an	d Symptoms				
Data of Initial Symptom Opents	1 1	D M V				
Date of Initial Symptom Onset:		(D, IVI, 11)				
Please mark an answer for ALL	symptoms indicating	g if they occurred during <u>this il</u>	<u>lness</u> :			
Fever	Yes No Unk	Difficulty breathing	Yes No Unk			
Vomiting/nausea	Yes No Unk	, ,	Yes No Unk			
Diarrhea	Yes No Unk	, ,	Yes No Unk			
Intense fatigue/weakness	Yes No Unk	Conjunctivitis (red eyes)	Yes No Unk			
Anorexia/loss of appetite	Yes No Unk	Skin rash	Yes No Unk			
Abdominal pain	Yes No Unk	Hiccups	Yes No Unk			
Chest pain	Yes No Unk					
Muscle pain	Yes No Unk	Unexplained bleeding	Yes No Unk			
Joint pain	Yes No Unk	If yes, please specify:				
Headache	Yes No Unk					
Cough [Yes No Unk	Other non-hemorrhagic sympton	oms: Yes No Unk			
		If yes, please specify:				
Section 3.	Hospitalizatio	n Information				
			: 10 DV DV			
At the time of this case report, i	is the patient hospital	lized or being admitted to the r	nospital?			
If yes, Date of Hospital Admission	n:/(D	, M, Yr)				
Health Facility Name: District: Village/Town:						
Is the patient in an ETU (isolation) or currently being placed there? \(\sum \text{Yes} \sum \text{No}\)						
If yes, date of isolation/admission to the ETU:/(D, M, Yr)						
Was the patient hospitalized or did he/she visit a health clinic previously for this illness? Yes No Unk						
and patient hoopitalized of		c proriodory <u>ioi uno in</u>				

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

If you Dates of II	oonitalizatio	-	1 1	(D. M.)(x)			
If yes, Dates of H					Village/Town:		
ricaliti ac	inty Name		District.		Village/10Wii.		
Section 4.	E	oidemiological	Risk Facto	ors and Expos	sures		
IN THE PAST ONE	(1) MONTI	H PRIOR TO SYMI	PTOM ONSET	<u>:</u>			
1. Did the patient have contact with a known case or any sick person before becoming ill? Yes No Unk							
	-	e line of informati					
Name of Source Case	Relation to Patient	Date of Last Contact (D, M, Y)	District	Village/Town	Was the person dead or alive ?		
					Alive Dead, date of death:/(D, M,		
					Alive Dead, date of death://(D, M,		
2. Did the patient attend a funeral in the one month before becoming ill? Yes No Unk							
-				•	to patient:		
					Village/Town:		
		cipate (carry or to			_		
3 Did the natient	travel outs	ide their home o	or village/tov	vn hefore hec	oming ill? Yes No Unk		
3. Did the patient travel outside their home or village/town before becoming ill? Yes Unk If yes, District: Date(s):/_//_/_ (D, M, Yr)							
Section 5.		Clinical Specim	ens and La	aboratory Tes	sting		
Has this patient ha	ad a sample	submitted previo	usly? 🗌 Ye	s No			
Submitting Health	Facility:			Submitter's Nar	me:		
Submitter's Phone	Submitter's Phone Number:		;	_ Submitter's Email:			
Sample 1:			<u>9</u>	Sample 2:			
Sample Collection	Date:	//(D,	M, Yr)	Sample Collect	ion Date:/ (D, M, Yr)		
Sample Type:	lood		;	Sample Type:	le Blood		
=	rtem heart blo	ood		=	-mortem heart blood		
Skin biopsy Saliva swab Saliva swab							
=		specify:		=	r specimen type, specify:		
Section 6. Case Report Form Completed by:							
Name:		Phone	:		_ E-mail:		
Section 7.		Patient C	outcome In	formation			
Please fill out this section at the time of patient recovery & discharge from the hospital OR at the time of patient death.							
Date Outcome Information Completed:/(D, M, Yr)							
Final Status of the Patient: Alive/Recovered Dead							
If the patient has recovered and been discharged from the hospital:							
Name of hospital discharged from: District:							
If the patient was isolated in an ETU, Date of discharge from isolation://(D, M, Yr)							

Date of discharge from the hospital:/	_/ (D, M, Yr)	
If the patient is dead:		
Date of Death:/(D, M, Yr)		
Place of Death: Community Hospital:		District:
Date of Funeral/Burial:/(D, M, Yr) F	uneral conducted by:	Family/community 🗌 Outbreak burial team
Place of Funeral: District:	Sub-county:	Village: