[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 Information

Patient's Surname: _____ **Other Names**:_____

Age: _____ ☐Years ☐Months **Gender:** ☐ Male ☐ Female

Phone Number of Patient/Family Member: _____

Status of Patient at Time of This Case Report: ☐ Alive ☐ Dead *If dead,* Date of Death: ___/___/___ (D, M, Yr)

Permanent Residence:
Head of Household :_____ Country: _____ District: _____
Sub-County: _____ Parish: _____ Village/Town: _____

Occupation:
☐ Healthcare worker; position: _____ healthcare facility: _____
☐ Other; please specify occupation: _____

Location Where Patient Became Ill: Country:_____
District: _____ Sub-County: _____ Village/Town: _____

Section 2. Clinical Signs and Symptoms

Date of Initial Symptom Onset: ____/____/_____ (D, M, Yr)

Please mark an answer for <u>ALL</u> symptoms indicating if they occurred during <u>this illness</u>:

Fever	☐ Yes	☐ No	☐ Unk		Difficulty breathing	☐ Yes	☐ No	☐ Unk
Vomiting/nausea	☐ Yes	☐ No	☐ Unk		Difficulty swallowing	☐ Yes	☐ No	☐ Unk
Diarrhea	☐ Yes	☐ No	☐ Unk		Sore Throat	☐ 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 symptoms:**	☐ Yes	☐ No	☐ Unk
					If yes, please specify: _____			

Section 3. Hospitalization Information

At the time of this case report, is the patient hospitalized or being admitted to the hospital? ☐ Yes ☐ No

If yes, Date of Hospital Admission: ____/____/_____ (D, M, Yr)

Health Facility Name: _____ District: _____ Village/Town: _____

Is the patient in an ETU (isolation) or currently being placed there? ☐ Yes ☐ 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 <u>for this illness</u>? ☐Yes ☐No ☐Unk

If yes, Dates of Hospitalization: ___/___/____ - ___/___/____(D, M, Yr)

Health Facility Name: _____ District: _____ Village/Town: _____

Section 4. Epidemiological Risk Factors and Exposures

IN THE PAST ONE(1) MONTH PRIOR TO SYMPTOM ONSET:

1. Did the patient have contact with a known case or any sick person <u>before</u> becoming ill? ☐Yes ☐No ☐Unk

If yes, please complete one line of information for each sick source case:

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, Yr)
		___/___/___			☐ Alive ☐ Dead, date of death: ___/___/___ (D, M, Yr)

2. Did the patient attend a funeral in the one month <u>before</u> becoming ill? ☐ Yes ☐ No ☐ Unk

If yes, Name of Deceased Person: _____ Relation to patient: _____

Date of Funeral: (D, M, Yr): ___/___/____ District: _____ Village/Town: _____

Did the patient participate (carry or touch the body)? ☐ Yes ☐ No

3. Did the patient travel outside their home or village/town <u>before</u> becoming ill? ☐ Yes ☐ No ☐ Unk

If yes, District: _____ Village/Town: _____ Date(s): ___/___/___ - ___/___/___ (D, M, Yr)

Section 5. Clinical Specimens and Laboratory Testing

Has this patient had a sample submitted previously? ☐ Yes ☐ No

Submitting Health Facility: _____ Submitter's Name: _____

Submitter's Phone Number: _____ Submitter's Email: _____

<u>Sample 1:</u> ☐

Sample Collection Date: ____/____/_____ (D, M, Yr)

Sample Type:

- ☐ Whole Blood
- ☐ Post-mortem heart blood
- ☐ Skin biopsy
- ☐ Saliva swab
- ☐ Other specimen type, specify: _____

<u>Sample 2:</u> ☐

Sample Collection Date: ____/____/_____ (D, M, Yr)

Sample Type:

- ☐ Whole Blood
- ☐ Post-mortem heart blood
- ☐ Skin biopsy
- ☐ Saliva swab
- ☐ Other specimen type, specify: _____

Section 6. Case Report Form Completed by:

Name: _____ Phone: _____ E-mail: _____

Section 7. Patient Outcome Information

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

<u>If the patient has recovered and been discharged from the hospital:</u>

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) Funeral conducted by: ☐ Family/community ☐ Outbreak burial team

Place of Funeral: District: _____ Sub-county: _____ Village: _____