

[NAME OF COUNTRY] VIRAL HEMORRHAGIC FEVER CASE INVESTIGATION FORM

Outbreak
Case ID:

Health
Facility
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: _____ Owner of Phone: _____

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

Permanent Residence:

Head of Household: _____ Address: _____ Parish: _____
Country of Residence: _____ State: _____ LGA: _____

Occupation:

- Farmer Butcher Hunter/trader of game meat Miner Religious leader Housewife Pupil/student Child
 Businessman/woman; type of business: _____ Transporter; type of transport: _____
 Healthcare worker; position: _____ healthcare facility: _____ Traditional/spiritual healer
 Other; please specify occupation: _____

Location Where Patient Became Ill:

Address: _____ State: _____ LGA: _____
GPS Coordinates at House: latitude: _____ longitude: _____
If different from permanent residence, Dates residing at this location: ___/___/___ - ___/___/___ (D, M, Yr)

Section 2. Clinical Signs and Symptoms

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

Please tick an answer for **ALL** symptoms indicating if they occurred during **this illness** between symptom onset and case detection:

- | | |
|---|---|
| Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| <i>If yes, Temp: ___° C Source: <input type="checkbox"/> Axillary <input type="checkbox"/> Oral <input type="checkbox"/> Rectal</i> | |
| Vomiting/nausea | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Intense fatigue/general weakness | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Anorexia/loss of appetite | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Abdominal pain | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Chest pain | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Muscle pain | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Joint pain | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Headache | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Difficulty breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Difficulty swallowing | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Sore throat | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Jaundice (yellow eyes/gums/skin) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Conjunctivitis (red eyes) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Skin rash | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Hiccups | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Pain behind eyes/sensitive to light | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Coma/unconscious | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Confused or disoriented | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |

Unexplained bleeding from any site Yes No Unk

If Yes:

- | | |
|--|---|
| Bleeding of the gums | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Bleeding from injection site | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Nose bleed (epistaxis) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Bloody or black stools (melena) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Fresh/red blood in vomit (hematemesis) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Digested blood/"coffee grounds" in vomit | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Coughing up blood (hemoptysis) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Bleeding from vagina,
other than menstruation | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Bruising of the skin
(petechiae/ecchymosis) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Blood in urine (hematuria) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |

Other hemorrhagic symptoms Yes No Unk

If yes, please specify: _____

Other non-hemorrhagic clinical symptoms: Yes No Unk

If yes, please specify: _____

Section 3. Hospitalization Information

At the time of this case report, is the patient hospitalized or currently being admitted to the hospital? Yes No
 If yes, Date of Hospital Admission: ___/___/___ (D, M, Yr) Health Facility Name: _____
 Address: _____ State: _____ LGA: _____
 Is the patient in isolation or currently being placed there? Yes No If yes, date of isolation: ___/___/___ (D, M, Yr)

Was the patient hospitalized or did he/she visit a health clinic previously for this illness? Yes No Unk
 If yes, please complete a line of information for each previous hospitalization:

Dates of Hospitalization	Health Facility Name	Address	State	Was the patient isolated?
___/___/___ - ___/___/___ (D, M, Yr)				<input type="checkbox"/> Yes <input type="checkbox"/> No
___/___/___ - ___/___/___ (D, M, Yr)				<input type="checkbox"/> Yes <input type="checkbox"/> No

Outbreak Case ID: _____

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 or suspect case, or with any sick person before 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	Dates of Exposure (D, M, Yr)	Address	State	Was the person dead or alive?	Contact Types**
		___/___/___ - ___/___/___			<input type="checkbox"/> Alive <input type="checkbox"/> Dead, date of death: ___/___/___ (D, M, Y)	
		___/___/___ - ___/___/___			<input type="checkbox"/> Alive <input type="checkbox"/> Dead, date of death: ___/___/___ (D, M, Y)	
		___/___/___ - ___/___/___			<input type="checkbox"/> Alive <input type="checkbox"/> Dead, date of death: ___/___/___ (D, M, Y)	

****Contact Types: (list all that apply)**

- 1 – Touched the body fluids of the case (blood, vomit, saliva, urine, feces)
- 2 – Had direct physical contact with the body of the case (alive or dead)
- 3 – Touched or shared the linens, clothes, or dishes/eating utensils of the case
- 4 – Slept, ate, or spent time in the same household or room as the case

2. Did the patient attend a funeral before becoming ill? Yes No Unk
 If yes, please complete one line of information for each funeral attended:

Name of Deceased Person	Relation to Patient	Dates of Funeral Attendance (D, M, Yr)	Address	State	Did the patient participate (carry or touch the body)?
		___/___/___ - ___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No
		___/___/___ - ___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Did the patient travel outside their home or village/town before becoming ill? Yes No Unk
 If yes, Address: _____ State: _____ Date(s): ___/___/___ - ___/___/___ (D, M, Yr)

4. Was the patient hospitalized or did he/she go to a clinic or visit anyone in the hospital before this illness? Yes No Unk
 If yes, Patient Visited: _____ Date(s): ___/___/___ - ___/___/___ (D, M, Yr)
 Health Facility Name: _____ Address: _____ State: _____

5. Did the patient consult a traditional/spiritual healer before becoming ill? Yes No Unk
 If yes, Name of Healer: _____ Address: _____ State: _____ Date: ___/___/___ (D, M, Yr)

6. Did the patient have direct contact (hunt, touch, eat) with animals or uncooked meat before becoming ill? Yes No Unk
 If yes, please tick all that apply:

Animal:	Status (check one only):
<input type="checkbox"/> Bats or bat feces/urine	<input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead
<input type="checkbox"/> Primates (monkeys)	<input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead
<input type="checkbox"/> Rodents or rodent feces/urine	<input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead
<input type="checkbox"/> Pigs	<input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead
<input type="checkbox"/> Chickens or wild birds	<input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead

- Cows, goats, or sheep Healthy Sick/Dead
 Other; *specify* _____ Healthy Sick/Dead

7. Did the patient get bitten by a tick in the past 2 weeks? Yes No Unk

Section 5. Clinical Specimens and Laboratory Testing

- Specimen/shipping instructions:**
- Label sample with **patient name, date of collection, and case ID**
 - Send sample **cold** with a **cold/ice pack**, and **packaged appropriately**.
 - Collect whole blood in a purple top (EDTA) tube – green or red top tubes acceptable if purple not available
 - **Preferred sample volume = 4ml** (minimum sample volume = 2ml)

Has this patient had a sample submitted previously? Yes No

Sample 1:

*Do not complete
IIVRI Only*

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

Sample Type:

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

Sample 2:

*Do not complete
IIVRI Only*

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

Sample Type:

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

Section 6. Case Report Form Completed by:

Name: _____ Phone: _____ E-mail: _____
 Position: _____ State: _____ Health Facility: _____
 Information provided by: Patient Proxy; *If proxy, Name:* _____ *Relation to Patient:* _____

Case Name:

Outbreak Case ID:

**** If the patient is deceased or has already recovered from illness, please fill out the next section.
 ** If the patient is currently admitted to the hospital, leave the next section blank (it will be completed upon discharge)**

Section 7. 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: ____/____/____ (D, M, Yr)

Final Status of the Patient: Alive Dead

Did the patient have signs of unexplained bleeding at any time during their illness? Yes No Unk

If yes, please specify: _____

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

Name of hospital discharged from: _____ State: _____

If the patient was isolated, Date of discharge from the isolation ward: ____/____/____ (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: _____ Other: _____

Address: _____ State: _____ LGA: _____

Date of Funeral/Burial: ____/____/____ (D, M, Yr) Funeral conducted by: Family/community Outbreak burial team

Place of Funeral/Burial:

Address: _____ State: _____ LGA: _____

Please tick an answer for ALL symptoms indicating if they occurred at any time during this illness including during hospitalization:

- Fever Yes No Unk
If yes, Temp: ____° C Source: Axillary Oral Rectal
- Vomiting/nausea Yes No Unk
- Diarrhea Yes No Unk
- Intense fatigue/general weakness Yes No Unk
- Anorexia/loss of appetite Yes No Unk
- Abdominal pain Yes No Unk
- Chest pain Yes No Unk
- Muscle pain Yes No Unk
- Joint pain Yes No Unk
- Headache Yes No Unk
- Cough Yes No Unk
- Difficulty breathing Yes No Unk
- Difficulty swallowing Yes No Unk
- Sore throat Yes No Unk
- Jaundice (yellow eyes/gums/skin) Yes No Unk
- Conjunctivitis (red eyes) Yes No Unk
- Skin rash Yes No Unk
- Hiccups Yes No Unk

Pain behind eyes/sensitive to light Yes No Unk

Coma/unconscious Yes No Unk

Confused or disoriented Yes No Unk

Other non-hemorrhagic clinical symptoms: Yes No Unk

If yes, please specify: _____