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Questionnaire for Passengers and Crew

MERS-CoV Aircraft Contact Investigation

DGMQ ID_Number_____

Questionnaire for Passengers and Crew, MERS-CoV Aircraft Contact Investigation

Identifying and Residency Information

1. Traveler's name: _____

2. Type of Traveler (circle): passenger crew

3. Home Phone: _____ 4. Mobile Phone: _____
(circle best number to reach at)

5. E-mail address: _____

6. Home address (or address for next 14 days if nonresident): _____

_____

7. State_____ 8. Zip _____

9. If non-US resident, country of residence: _____

Attempt(s) to reach traveler:

Date	**Time**	**Outcome**	**Message left/e-mail sent**
		Interview completed / not completed	
		Interview completed / not completed	
		Interview completed / not completed	
		Interview completed / not completed	
		Interview completed / not completed	

Name of person answering the questions (if not traveler): _____

Relationship of person answering questions to traveler: _____

Name of Interviewer: _____

Agency/Affiliation of Interviewer:_____

Verbal consent/parental permission obtained? Circle: Yes / No For serology? Yes / No

For minors (13-17): Assent obtained? Circle: Yes / No If NO, parent interviewed on child's behalf? Circle: Yes / No Assent for serology? Yes / No

Interview date (mm/dd/yy) ___/___/14 □ Telephone □ In-person □ E-mail □ Other _____

A. Demographic Information

10. Age: _____ years / months (circle one)

11. Sex (circle one): M F

B. Flight History for Passenger (for crew member, skip to Section C)

The airline(s) has/have indicated that you were a passenger on the following flight(s). The next set of questions pertain to that/those specific flight(s).

Questions 12-14 should be repeated for each flight, as applicable

NOTE: If passenger was not on any of the above flights, the interview is completed.

Questions for Flight(s)

12a. Confirm passenger traveled on [check flight(s) below]

O	Flight Leg A, May 1st, 2014	□ Yes	□ No	□ Unsure
O	Flight Leg B, May 1st, 2014	□ Yes	□ No	□ Unsure
O	Flight Leg C, May 1st, 2014	□ Yes	□ No	□ Unsure
O	Flight Leg D, May 1st, 2014	□ Yes	□ No	□ Unsure

If NO* or unsure, provide code share info. *Check other flights. If not on any of the flights, then the interview is complete.

If YES,

13a: Did you sit in your assigned seat for this entire flight ?

□ Yes **– Skip to Question 14a** □ No □ Don't remember

13a.1. If no, how long did you sit in your assigned seat?

□ <30 minutes □ 30-60 minutes □ > 60 minutes □ Don't remember

13a.2. What other seat number did you sit in for all or part of the flight?

Seat Number: _____ □ Don't remember

13a.3. If passenger doesn't remember which seat number, ask to describe which part of the plane she or he sat in. _____

13a.4. How long did you sit in this other seat?

□ <30 minutes □ 30-60 minutes □ > 60 minutes □ Don't remember

14a. Were you traveling with anyone else on this flight?

□ Yes **–complete table below** □ No **– Skip to Question 14b**

14.a.1. Who did you travel with? [This information will help make sure we can contact her or him about possible exposure during the flight.]

Name (last, first)	Relation*	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

*A. friend B. colleague C. household member** D. non-household family member

** If household member(s), ask to interview that person when done with this interview

14b. Did you come into contact with anyone who seemed ill with respiratory symptoms (such as cough or difficulty breathing) or appeared feverish? □ Yes □ No

14c. Did you assist them in any way? If yes, please explain.

_____

C. Flight History for Crew Member (For passenger, skip to Section D)

15. Confirm that crew member worked on

O Flight Leg A, May 1st, 2014	□ Yes	□ No	□ Unsure
O Flight Leg B, May 1st, 2014	□ Yes	□ No	□ Unsure
O Flight Leg C, May 1st, 2014	□ Yes	□ No	□ Unsure
O Flight Leg D, May 1st, 2014	□ Yes	□ No	□ Unsure

IF NO, *interview is complete.* Thank the person for her/his time.

If YES, continue

16. Crew type (circle all that apply) or Cabin for passenger

Flight Deck: Captain
First Officer
Flight engineer/ navigator
Other (such as jumpseater; specify): _____

Cabin: First Class
Business Class

Economy Class(specify section if assigned to a specific one): _____

Lead Flight Attendant

17. Did you come into contact with anyone who seemed ill with respiratory symptoms (such as cough or difficulty breathing) or appeared feverish? □ Yes □ No

18. Did you assist them in any way? If yes, please explain.

_____

D. Illness and Medical History

19. Have you been ill since the day of the flight? □ Yes □ No

IF YES, GO TO 20. IF NO, GO TO APPENDIX I (SEROLOGY). THEN…

- **Read end script for asymptomatic contact.**
- **Send Information Notice to traveler by e-mail or fax.**

20. Have you had any of the following symptoms since your flight?

a. **Fever (measured temp of > 100.4^0 F (38^0 C)**
□ Yes (Temp if known _____°) □ No □ Don't Know

b. **Coughing** □ Yes □ No □ Don't Know

c. **Difficulty breathing or shortness of breath** □ Yes □ No □ Don't Know

d. **Wheezing** □ Yes □ No □ Don't Know

e. **Pain with coughing or breathing** □ Yes □ No □ Don't Know

f. **Other symptom(s):** □ Yes; List: _____ □ No □ Don't Know

IF NO/DON'T KNOW TO 20 a-e, GO TO APPENDIX I (SEROLOGY). THEN…

- **Read end script for asymptomatic contact.**
- **Send *Informational Notice for MERS-CoV Exposure on Airplane* to traveler by e-mail or fax.**

21. What date did you first become ill with these symptoms? (Date : ____/____/14)

If sick on or before date of flight, complete interview, then consult medical officer before giving advice to patient.

22. Are you still sick? □ Yes □ No

22a. If NO, when did you feel better? Date__/__/14

23. Did you see a doctor for this illness? □ Yes □ No

If YES,

a. What date were you seen? Date__/__/14
b. Did you receive any treatment for the illness? □ Yes □ No
    i. If YES, specify: _____
c. Were you tested by a medical provider for the illness (including, but not limited to, providing a blood sample, or nasal or throat swab) since the day of your flight? □ Yes □ No
    i. If YES – Specify test or what kind of specimen was tested for you (e.g., blood, nasal swab, throat swab.): _____
        1. Date (mm/dd/yy) ____/____/14
        2. Facility where tested_____
d. Were you admitted to the hospital (kept overnight, not just in emergency room)? YES/NO If yes, which hospital? _____

24. Do you have any medical conditions that you are treated for regularly?
□ Yes (Specify: _____) □ No □ Don't Know

25. For women: Are you currently pregnant? □ Yes □ No □ Don't Know

E. GEOGRAPHIC EXPOSURES

26. Have you visited the Middle East since April 17th?
□ Yes □ No **If NO, skip to Question 28.**
a. If YES : Dates of visit (mm/dd/yy) ____/____/14 to ____/____/14
b. List country(ies): _____
c. (Omit for crew) What was the purpose of your trip? (check all that apply)

□ Visit family/friends □ Personal travel □ Business □ Study □Other, specify_____

27. While you were in the Middle East, did you:

a. Have any close contact with someone who was sick with MERS-Coronavirus?
□ Yes □ No
b. Have any close contact with someone who was sick with a serious respiratory infection, such as pneumonia? □ Yes □ No

c. Visit a health care facility? □ Yes □ No

d. (Omit for crew) Work in a health care facility? □ Yes □ No

e. Have any animal exposures? □ Yes □ No
If yes: name animals
1: _____ (describe) _____, date:____/____/____
2: _____ (describe) _____, date:____/____/___
3: _____ (describe) _____, date:____/____/____

F. Household Contacts

28. Has anyone in your household or someone else you have had close contact with had fever, cough, difficulty breathing, or other symptoms similar to what you described?

□ Yes *** □ No □ Don't Know (*** Note this person's name and contact information on the form for follow-up by local health department.)

1. Name(s): _____
   Relationship: _____
   Symptoms: _____
   Date of onset (mm/dd/yy) ____/____/____
   Address: _____
   Phone #: _____
2. Name: _____
   Relationship: _____
   Symptoms: _____
   Date of onset (mm/dd/yy) ____/____/____
   Address: _____
   Phone #: _____

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Serology Consent/Assent Script for Asymptomatic Passengers and Crew

As part of our contact investigation we are asking passengers and crew to get a blood test for MERS.

The test will help tell us if some people exposed to MERS can be infected without showing symptoms. This would involve drawing a small amount of blood (for adults 1 teaspoon, for infants or young children half a teaspoon or less). There will be no cost to you for doing this testing. Drawing blood can cause some pain, bruising or a small amount of bleeding at the site of the blood draw, and can make some people feel lightheaded.

We will give you the results of the test, but they will not be available in time to make any decisions about your health care. Leftover blood will be stored at CDC and might be used for MERS testing in the future, such as developing new tests for MERS infection. If you agree to do the blood test, we will follow up with you at a later date (in approximately 2-3 weeks) with more details about how and where to have your blood drawn.

Do you have any questions?

Would you be willing to let us do a MERS blood test? Yes No

If NO: thank the person for their time.

Case ID# _____

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Chart Abstraction Form – Legionnaires' Disease

SECTION I. SCREENING FOR SUSPECT LD CASES

MRN:_____

Encounter (FIN): _____

Gender: _____

DOB: _____ Age: _____ Race/Ethnicity: _____

Type of Residence: □ Home □ LTCF □ Other _____

Todays date: __ / __ / __

Date of admission: __ / __ / __

Abstractors initials: _____

Did any of the following develop ≥48 hours of admission (do not count if present on admission)?

1. Pneumonia symptoms? (Cough, shortness of breath)
□ Yes □ No (if yes, then continue to Section II)

2. Abnormal CXR / CT suggestive of pneumonia/infiltrate?
□ Yes □ No (if yes, then continue to section II)

3. Was another etiology identified (other than Legionella)?
□ Yes □ No (if yes, then stop)

Case ID# _____

SECTION II. TYPE OF CASE

Information Source (check all that apply):

□ hospital chart

□ other (if other specify) _____

1. **Type of exposures to Hospital A during incubation period *(check all that apply)*:**
   □ Inpatient □ Outpatient □ Visitor □Volunteer □Employee

2. **Case definition:**
   □ Confirmed Case □ Suspected Case □ Possible Case □ Subclinical case

3. **Case Classification*:***
   □ Definitely outbreak-associated □ Possibly outbreak-associated
   □ Non-outbreak associated

If non-outbreak-associated, END HERE. Otherwise, continue to next page.

SECTION III. LEGIONELLA-SPECIFIC TESTING

1. **Respiratory specimen collected and processed specifically for *Legionella* culture?**
   _____ Yes _____ No _____ Unknown

   a.) **If YES,**
   Specimen type: (e.g., expectorated sputum, BAL, etc.) _____
   Collected Date: ____/____/ ____ Laboratory Name:_____
   Results:_____

   b.) **If NO,**
   Respiratory specimen collected for any culture?
   _____ Yes _____ No _____ Unknown
   If Yes,
   Specimen type: (e.g., expectorated sputum, BAL, etc.) _____
   Collected Date: ____/____/ ____ Laboratory: _____
   Results:_____

2. **Urine specimen collected for *Legionella* urine antigen testing?**
   _____ Yes _____ No _____ Unknown
   Collected Date: ____/____/ ____ Laboratory Name: _____
   Results: _____

3. **Other *Legionella* testing? _____**

SECTION IV. MEDICAL HISTORY

□ **COPD/Emphysema/Chronic Lung Disease**

□ **Diabetes**

□ **Congestive Heart Failure**

□ **History of stroke/CVA**

□ **Chronic Renal Insuffiency (CRI/CKD) or End-Stage Renal Disease (ESRD)**

□ **Cirrhosis / Liver Disease**

□ **Cancer (Type: _____; Date of diagnosis __/__/__)**

□ **Organ Transplant (Type:_____) Date of transplant: __ / __ / __**

□ **Bone Marrow Transplant; Date of transplant: __ / __ / __**

□ **HIV/AIDS, CD4 count: _____ Date: __ / __ / __**

□ **Dementia**

□ **Taking systemic steroid**

□ **History of chemotherapy Date: __ / __ / __ (Is this 1st cycle of induction chemo? □ Yes □ No)**

□ **History of radiation Date: __ / __ / __**

□ **History of pneumonia in prior year, Date: __ / __ / __**

□ **Other (_____)**

□ **Other (_____)**

History of smoking: □ Yes □ No □ Unknown
If yes: □ Current □ Former □ Unknown

History of alcohol abuse: □ Yes □ No □ Unknown

History of other substance abuse: □ Yes □ No □ Unknown
Specify substance(s): _____

SECTION V. SIGNS AND SYMPTOMS

□ Shortness of breath; Date of onset: __ / __ / __

□ Cough; Date of onset: __ / __ / __

□ Fever >100.5°F; Date of onset: __ / __ / __

□ Diarrhea (3 stools/24h); Date of onset: __ / __ / __

□ Nausea or Vomiting; Date of onset: __ / __ / __

□ Confusion (altered mental status); Date of onset: __ / __ / __

□ Other (_____);Date of onset: __ / __ / __

□ Other (_____);Date of onset: __ / __ / __

BEST SYMPTOM ONSET DATE: __ / __ / __

(If the patient did not have prior respiratory symptoms, choose, the onset date of cough or shortness of breath, whichever occurs first. Otherwise, use the earliest date when other symptoms suggestive of Legionella infection began.)

SECTION VI. RADIOGRAPHIC FINDINGS

Document any radiographic findings 14 days after onset of symptoms above. If multiple chest images are available, report the first for which evidence of pneumonia is noted.

□ Chest X-ray

If Yes, when and what were the findings?
Date: ____/____ / _____
□ Normal □ Abnormal
Result:
□ New Infiltrate □ Old / Unchanged Infiltrate □ Indeterminate □ Consolidation
□ No infiltrate □ Not available / Unknown
Findings (impression): _____

□ CT Scan

If Yes, when and what were the findings?
Date: ____/____ / _____
□ Normal □ Abnormal
Result:
□ New Infiltrate □ Old / Unchanged Infiltrate □ Indeterminate □ Consolidation
□ No infiltrate □ Not available / Unknown
Findings (impression): _____

SECTION VII. VITAL SIGNS

Highest O2 demand (FiO2): _____ Date (*earliest*):_____

Pulse ox (lowest recorded): _____ Date: _____
Tmax: _____ Date _____

SECTION VIII. LABORATORY VALUES

TEST	Result	Date
WBC (lowest)		____ / ____ / ____
% Neutrophils		____ / ____ / ____
% Lymphocytes		____ / ____ / ____
WBC (highest)		____ / ____ / ____
Hemoglobin (lowest)		____ / ____ / ____
Platelets (lowest)		____ / ____ / ____
Na (lowest)		____ / ____ / ____
Cr (highest)		____ / ____ / ____
Required dialysis	□ Yes □ No	
AST (highest)		____ / ____ / ____
ALT (highest)		____ / ____ / ____
Total bilirubin (highest)		____ / ____ / ____
Ferritin (highest)		____ / ____ / ____
CRP (highest)		____ / ____ / ____
ESR (highest)		____ / ____ / ____

SECTION IX. INVASIVE PROCEDURES

Document procedures done 14 days prior to the onset of symptoms above

Procedure name	Date
□ NG/OG tube placement	____ / ____ / ____
□ ET/OT/Other Intubation	____ / ____ / ____
□ Lumbar puncture	____ / ____ / ____
□ Thoracentesis	____ / ____ / ____
□ Paracentesis	____ / ____ / ____
□ Bronchoscopy	____ / ____ / ____
□ Central line placement	____ / ____ / ____
□ Arterial line placement	____ / ____ / ____
□ Other_____	____ / ____ / ____
□ Other_____	____ / ____ / ____

SECTION X. ANTIBIOTICS / IMMUNOSUPPRESION REGIMENS					
Antibiotic / immunosuppressive therapy	**Dose**	**Route**	**Start Date**	**End Date**	**Check if continued as outpatient**
□ Levofloxacin (Levoquin)					
□ Moxifloxacin					
□ Ciprofloxacin (Cipro)					
□ Azithromycin (Zithromax)					
□ Erythromycin					
□ Rifampin					
□ Rifapentine					
□ Linezolid					
□ Tetracycline					
□ Doxycycline					
□ Quinupristin/ dalfopristin (Synercid)					
□ Chemotherapy regimen (specify): _____					
□ Radiation therapy (specify): _____					
□ Systemic steroids (specify): _____					
Other (specify): _____					
Other (specify): _____					
Other (specify): _____					
Other (specify): _____					

SECTION XI. CLINICAL OUTCOMES

□ ICU Stay

a.) If ICU stay,

a. Number of days in ICU: _____ (count days where any time was spent in ICU)

DISPOSITION:

□ Still Hospitalized
□ Transferred to another facility (list:_____)
□ Discharged Home
□ Unknown
□ Deceased

b.) If deceased,

a. Date of death: _____ (mm/dd/yyyy)
b. Was a post-mortem examination performed? ___Yes ___No ____Unknown
i. If yes, are tissue specimens available? ____ Yes ____No ____ Unknown

DISCHARGE DIAGNOSIS

□ Legionellosis

□ Pneumonia

If yes, Etiology: _____ Lab Test(s): _____

□ Other Dx: _____

SECTION XII. EXPOSURES

□ Hospitalized before; Date of admission: __ / __ / ____ ; Date of Discharge: __ / __ / ____
□ ICU stay; if yes # of days in ICU___________ days
□ Intubated
Discharge diagnosis: □ Legionellosis □ Pneumonia; etiology:_____________________
□ Other diagnosis; specify: _______________________________

□ Hospitalized before; Date of admission: __ / __ / ____ ; Date of Discharge: __ / __ / ____
□ ICU stay; if yes # of days in ICU___________ days
□ Intubated
Discharge diagnosis: □ Legionellosis □ Pneumonia; etiology:_____________________
□ Other diagnosis; specify: _______________________________

□ Hospitalized before; Date of admission: __ / __ / ____ ; Date of Discharge: __ / __ / ____
□ ICU stay; if yes # of days in ICU___________ days
□ Intubated
Discharge diagnosis: □ Legionellosis □ Pneumonia; etiology:_____________________
□ Other diagnosis; specify: _______________________________

OUTPATIENT VISITS to Hospital A or associated clinics (including rehab visits)

Did patient have any outpatient visits during the 2-10 days prior to symptom onset?
_____ Yes _____ No _____ Unknown

If yes, list location of visits and name of clinic:

Name of Campus	Clinic (e.g., Primary Care, Cardiology)	Building	Room#	Date(s) of Visit

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Hypothesis Generating Questionnaire
Gastroenteritis

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Outbreak of Diarrheal Illness in American Samoa:
Hypothesis Generating Questionnaire for Gastroenteritis Complaints

Hi! My name is_____. We are working with the Health department to try and figure out what caused the outbreak of diarrhea. Could we please ask you a few questions? Your answers will help prevent diarrhea in the future.

Your answers will be completely confidential. That means we will not share your personal information with anybody else.

Thank you!!!

1) INTERVIEWER INFORMATION:

Interviewer name:_____

Date:_____

2) DEMOGRAPHIC INFORMATION:

Patient name:_____

Name (if not the patient):_____

Relationship to child (if patient is <18 years of age):_____

Sex: M F

DOB:_____

Nationality:
American Samoan
Western Samoan
Other Pacific Islander
Asian
White, non-Hispanic
Black, non-Hispanic
Unknown

Name of Village:_____

Number of people in household:
Number of adults:_____
Number of children:_____

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Place of work:_____

3) CLINICAL SYMPTOMS:

According to our records, you came to the Emergency room for diarrhea on (DATE). Please think back to the week before you got sick.

When did you first get sick (mm/dd/yyyy)? _____

On what day did diarrhea begin (mm /dd /yyyy)?_____

For how many days did you experience diarrhea? : _____

When at its worst, what was the total number of episodes of diarrhea you experienced in a 24 hour period?

- 1-3 per day
- 4-6 per day
- 5-10 per day
- 10+ per day

What symptoms did you have? : *Circle all that apply.*

- Fever
- Vomiting
- Poor feeding
- Irritable
- Bloody diarrhea
- Non-bloody diarrhea
- Watery diarrhea
- Fatigue/Weakness
- Chills
- Headache
- Abdominal cramps
- Nausea
- Bodyaches

What was the first place you went to seek treatment?

- Emergency room
- Local clinic
- Village healer
- Other:_____

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Did you take any medications for the diarrhea?

Over the counter: Yes No /Name:_____

From the hospital: Yes No /Name:_____

Do you use any at-home remedies for diarrhea? Yes No /Name:_____

Did you hear about diarrhea from family/friends recently? Yes No

Did you hear about diarrhea from on TV/in the newspaper recently? Yes No

How long after you first got sick did you seek medical treatment?
- Less than 1 day
- 1 – 2 days
- 3 – 4 days
- 5 – 6 days
- 7 days or more

What prompted you to go to the emergency room? *Circle all that apply.*
- Diarrhea
- Dehydration
- Fever
- Stomach / gut pain
- Unable to eat
- To get medicine
- Worried about ameba
- Friend or family member suggested going
- Other:_____

4) TRAVEL / EVENT EXPOSURES:

Did you attend flag day? Yes No

In the week before illness, did you travel anywhere outside the village? Yes No

If yes, where?
Other village(s): (Village name(s):_____
Off-island (Name of location):_____

In the week before illness, did you have contact with anyone who traveled:
Outside the village: Yes No
Off-island: Yes No

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In the week before illness, were you exposed to a school or child-care facility? Yes

In the week before illness, were you exposed to any flies? Yes No

Is your home screened? Yes No

Do you have a refrigerator? Yes No

In the week before illness, did you attend any special events where food was served or catered (weddings, community meetings, church events, etc.)? Yes No
If yes:
#1 Type of event:_____
#1 Was there a sink with soap and water to wash your hands? Yes No

#2 Type of event:_____
#2 Was there a sink with soap and water to wash your hands? Yes No

In the week before illness, did you go swimming or have other recreational water exposures (fishing, etc.)? Yes No

If yes, please describe:

---

5) HOUSEHOLD WATER EXPOSURES:

What is the water supply source for your home or residence? *Circle all that apply*.

- ASPA water
- Village water
- Rain water
- Vending machines
- Bottled water
- Other:_____

If multiple sources, what source is usually used for each?

Drinking: _____
Cooking: _____
Bathing: _____
Washing clothing: _____
Cleaning:_____Hand
washing: _____

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Where do you typically wash your hands at home?

_____

When do you typically wash your hands at home?

_____

When you don't wash your hands at home, what are some reasons why?

_____

Does the household usually boil or filter water before use for cooking?

- Boiling
- Filtering
- No treatment

Does the household usually boil or filter water before use for drinking?

- Boiling
- Filtering
- No treatment

6) SEWAGE EXPOSURES:

What type of sewage disposal does your house have?

- ASPA sewage
- Septic Tank
- Cesspool
- Nothing
- Other :_____

41. How do you dispose of trash?

- ASPA
- Self-disposal
- Other:_____

IF ASPA:
How many days per week is trash collected by ASPA?
_____days per week

IF SELF DISPOSAL:
How many days per week is trash taken outside the house?

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_____days per week

How many days per week is trash taken off the property?
_____days per week

Where do you take the trash to:_____

7) FOOD EXPOSURES:

What do you eat on a typical day?

Breakfast
What do you eat?

_____

_____

Where do you eat? _____

Lunch
What do you eat?

_____

_____

Where do you eat? _____

Dinner
What do you eat?

_____

_____

Where do you eat? _____

Snacks
What do you eat?

_____

_____

Where do you eat? _____

Drinks
What do you drink?

_____

_____

Where do you usually shop for groceries?

_____

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What restaurants do you usually go to?

_____

8) ILL CONTACTS:

Do you know anyone else who is ill? Yes No

#1 Relation to you:_____
#1 Does this person live with you?:_____
#1 Village:_____

#2 Relation to you:_____
#2 Does this person live with you?:_____
#2 Village:_____

#3 Relation to you:_____
#3 Does this person live with you?:_____
#3 Village:_____

#4 Relation to you:_____
#4 Does this person live with you?:_____
#4 Village:_____

#5 Relation to you:_____
#5 Does this person live with you?:_____
#5 Village:_____

9) PERSONAL OPINION

How do you think you got sick?

_____

Is there anything else you would like to share with us, relating to the diarrhea outbreak?

_____

THANK YOU SO MUCH FOR YOUR TIME!!!
We truly appreciate your talking to us today.

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Household Line Listing

Measles

Measles Case ID # _____ Case-Patient's Name _____

List Dates of HH Visits __ _/__ _/__ _ __ _/__ _/__ _ __ _/__ _/__ _ Household Location: Municipality _____ Village _____

Number of Rooms in the House ____ Number of Persons Living in the House _____

HH No.	First Name Last Name	Sex	Date of Birth	Age (y, m)	Mother's First Name (If age 39 or less)	Fever and rash in the last 2 months (May/June)?	Had measles before this year?	MMR Doses	MMR Dates	Doses obtained (check one)	Lived/slept at least one night in the HH from 3 days prior and 3 days after rash onset of 1st case?
1			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	__ by history __ from record	Yes No
2			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No
3			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No
4			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No
5			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No
6			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No
7			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No
8			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No

HH No.	First Name Last Name	Sex	Date of Birth	Age (y, m)	Mother's First Name (If age 39 or less)	Fever and rash in the last 2 months (May/June)?	Had measles before this year?	MMR Doses	MMR Dates	Doses obtained (check one)	Lived/slept at least one night in the HH from 3 days prior and 3 days after rash onset of 1st case?
9			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No
10			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	__ by history __ from record	Yes No
11			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No
12			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No
13			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No
14			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No
15			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No
16			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No
17			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No

HH No.	First Name Last Name	Sex	Date of Birth	Age (y, m)	Mother's First Name (If age 39 or less)	Fever and rash in the last 2 months (May/June)?	Had measles before this year?	MMR Doses	MMR Dates	Doses obtained (check one)	Lived/slept at least one night in the HH from 3 days prior and 3 days after rash onset of 1st case?
18			__ /_ __/_ __			Yes Date of onset __ _/__ _/__ _ No	Yes No	0___ 1___ 2___ 3___	__ _/_ __/_ __ __ _/_ __/_ __ __ _/_ __/_ __	_ by history _ from record	Yes No

Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

Dengue and chikungunya report form

DENGUE & CHIKUNGUNYA REPORT FORM

U.S. Virgin Islands Department of Health
Charles Harwood Complex, 3500 Estate Richmond
Christiansted, St. Croix, USVI 00820-4370
Tel. (340) 773-1311 x3241, Fax (340) 718-1508

SUSPECTED CHIK? Yes ☐ No ☐

Today's date: _____ Day/Month/Year

Case number	Specimen #	Days post onset (DPO)	Type	Date Received	Specimen #	Days post onset (DPO)	Type	Date Received
SAN ID / GCODE	S1				S3			
	S2				S4			

Please read and complete ALL sections

Patient Data — Hospitalized due to this illness: No ☐ Yes ☐ → Hospital Name: Record Number:

Name of Patient: _____ (Last Name / First Name / Middle Name or Initial)

If patient is a minor, name of father or primary caregiver: _____ (Last Name / First Name / Middle Name or Initial)

Fatal: Yes ☐ No ☐ Unk ☐

Mental status changes: Yes ☐ No ☐ Unk ☐

Home (Physical) Address

Home address here

City: Zip code: _____-_____

Tel: Other Tel:

Residence is close to:

Work address:

Physician who referred this case

Name of Healthcare Provider:

Tel: Fax: Email:

Do you want to receive laboratory results via Fax or Email?

Patient's Demographic Information

Date of Birth: _____ Day/Month/Year

Age: _____ months Sex: M F

or Age: _____ years Pregnant: Y N UNK

Weeks pregnant (gestation): ____

Who filled out this form?

Name (complete)

Relationship with patient:

Tel: Fax: Email:

Must have the following information for sample processing

Day/Month/Year

Date of first symptom: _____

Date specimen taken:

First sample _____

Second sample _____

How long have you lived in this city? _____ Country of birth _____

During the 14 days before onset of illness, did you TRAVEL to other cities or countries?

☐ Yes, another country ☐ Yes, another city ☐ No ☐ Unknown

WHERE did you TRAVEL? _____

Are there any sick contacts in your household?

Yes ☐ No ☐

PLEASE indicate below the signs and symptoms that the patient had at the time of illness

	Yes	No	Unk
Fever lasting 2-7 days			
Fever (>38°C/101°F)			
Platelets ≤100,000/mm^3			

Platelet count: _____

Any hemorrhagic manifestation

	Yes	No	Unk
Petechiae			
Purpura/Ecchymosis			
Vomit with blood			
Blood in stool			
Nasal bleeding			
Bleeding gums			
Blood in urine			
Vaginal bleeding			
Positive urinalysis (over 5 RBC/hpf or positive for blood)			

Tourniquet test ☐ Pos ☐ Neg ☐ Not done

Evidence of capillary leak

Lowest hematocrit (%)

Highest hematocrit (%)

Lowest serum albumin

Lowest serum protein _____

Lowest blood pressure (SBP/DBP) _____/_____

Lowest pulse pressure (systolic - diastolic) _____

Lowest white blood cell count (WBC) _____

Symptoms	Yes	No	Unk
Rapid, weak pulse			
Pallor or cool skin			
Chills			
Rash			
Headache			
Eye pain			
Body (muscle/bone) pain			
Joint pain			
Anorexia			

Warning signs	Yes	No	Unk
Persistent vomiting			
Abdominal pain/Tenderness			
Mucosal bleeding			
Lethargy, restlessness			
Liver enlargement >2cm			
Pleural or abdominal effusion			

Additional symptoms

Diarrhea			
Cough			
Conjunctivitis			
Nasal congestion			
Sore throat			
Jaundice			
Convulsion or coma			
Nausea and vomiting (occasional)			
Arthritis (Swollen joints)			
Missed school/work due to this illness			
Unable to walk during this illness			

Form Approved
OMB No. 0920-1011
Expiration 03/31/2017

Suspected Chikungunya Case Questionnaire August 16, 2014

Interviewer:_____ Date of Interview: ___/___/_____

Name of person/parent giving consent:_____ □ Refused Interview

If case-patient is not available, ask for an alternate contact number or time to call back to speak with case patient. Alternate number _____ Alternate day/time _____

1.) We have your age (your child's age) as _____, is this correct? [*If no*] What is the correct age? ____

a. [*For parents <17 year old child*] Can I ask what is your age and sex?
Age in years____ Sex: □ Male □ Female

2.) Per our records, a sample was taken for chikungunya testing on __ __ /__ __ /2014 , does this sound correct?
□ Yes □ No
[*If this is not correct*] Can you recall which date the sample was drawn? __ __ /__ __ /2014

3.) Besides yourself (or your child), has anyone else in your household had similar symptoms?
□ Yes *(go to question 4)*
□ No *(go to question 5)*
□ Don't know *(go to question 5)*

4.) How many of these household members with similar symptoms sought medical care? _____

5.) How long did the initial joint pain last when you were tested for Chikungunya? _____ days after symptoms started.

6.) Do you have any joint pain (i.e., pain in your wrists, ankles, hands or feet) or joint swelling today that you think might be related to your recent illness?
□ Yes *(go to question 8)*
□ No *(go to question 7)*
□ Don't know *(go to question 7)*

7.) Have you (or your child) had any joint pain or swelling in the last week that you think might be related to your recent illness?
□ Yes *(go to question 8)*
□ No *(go to question 9)*
□ Don't know

8.) How often do you (your child) experience joint pain or swelling that you think might be related to your recent illness?
□ Daily
□ Two to three times per week
□ Once per week
□ Less than once per week
□ Don't know

9.) What is your current employment status?

□ Working (*go to question 10*)
□ Retired (*go to question 13*)
□ Not Working (*go to question 13*)
□ Child (*go to question 15*)
□ Refused

10.) In the time since you have visited the doctor for suspected chikungunya, have you missed time from work because of your illness?

□ Yes (*go to question 11*)
□ No (*go to question 16*)

11.) Have you (your parent) returned to work?

□ Yes (*go to question 12*)
□ No (*go to question 16*)

12.) How many days of work did you miss? _____ (*go to question 16*)

13.) In the time since you visited the doctor for suspected chikungunya, have you been unable to do your normal chores and activities?

□ Yes (*go to question 14*)
□ No (*go to question 16*)

14.) How many days of chores/activities have you missed? _____ (*go to question 16*)

15.) Have you (or has your parent) had to miss work to care for your sick child (or you)?

□ Yes (*go to question 11*)
□ No (go to question 16)

16.) Were you been hospitalized due to your illness for which you were tested for chikungunya?

□ Yes (*go to question 17*)
□ No (*go to question 18*)

17.) How many days were you hospitalized? _____

18.) Did you seek additional medical attention following the date your sample was drawn for suspected chikungunya?

□ Yes (*go to question 19*)
□ No (*go to question 20*)

19.) How many times did you seek medical attention? _____ healthcare visits

---

20.) Do you have a history of chronic joint pain prior to being diagnosed with chikungunya?

□ Yes
□ No

Thank you for answering our additional question. The information you have provide will let us learn more about chikungunya and how the disease is affecting you and other people in your community.

Would you be willing for the health department to contact you again related to your illness? □ Yes
□ No

Finally, do you have any questions for me?

CHIKUNGUNYA INVESTIGATION — HOUSEHOLD INTERVIEW FORM

Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

TEAM #: _____ DATE:_____/_____/_____ Household ID (e.g., SJ-1-A):_____-_____-_____

GPS Coordinates:_____._____,_____._____SANID of lab-positive case: _____

How many people live in this house?_____people
List all members of household below put yourself first.

Head of household contact number to facilitate return of test results:_____

	Name (First, Paternal, Maternal)	**Age**	**Gender**	**Participate?**	**Place sticker here**
1			M / F	Yes / No	
2			M / F	Yes / No	
3			M / F	Yes / No	
4			M / F	Yes / No	
5			M / F	Yes / No	
6			M / F	Yes / No	
7			M / F	Yes / No	
8			M / F	Yes / No	

CHIKUNGUNYA INVESTIGATION — HOUSEHOLD INTERVIEW FORM

Household Characteristics

Housing type (check only one): ☐ One story house ☐ Two story house ☐ Apartment/condo building

☐Public housing ☐ Temporary shelter

Has anyone in your immediate household traveled outside of Puerto Rico in the past 3 months? ☐ Yes ☐ No

Has anyone in your household been sick in the past 3 months? ☐ Yes ☐ No

Does your home have screened windows and doors? ☐ All rooms ☐ Some rooms ☐ No

Do you regularly use air conditioning in your home? ☐ Yes, in all rooms ☐ Yes, but only in some rooms ☐ No

Do you regularly leave your doors or windows open? ☐ Daytime only ☐ Night-time only ☐ Always ☐ Never

Do you use mosquito coils in your house or patio? ☐ Yes ☐ No

Do you use citronela in your house or patio to keep mosquitoes away? ☐ Yes ☐ No

Notes:

Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

Chikungunya Investigation - Individual Interview Form

Team #:_____Interviewer:_____Date of interview:_____/_____/_____

Individual ID (e.g., SJ-1-A-1):_____-_____-_____-_____

1. Name: _____
First (given) Initial Paternal Maternal

2. Gender: ☐ Male ☐Female 3. Date of Birth (MM/DD/YYYY):_____/_____/_____

4. How long have you been living in Puerto Rico?_____years

5. Have you been told by a clinician that you have any of the following medical conditions?

☐ Diabetes ☐ High blood pressure ☐ Heart disease ☐ High cholesterol
☐ Stroke ☐ Kidney disease ☐ Liver disease ☐ Thyroid disease
☐ Asthma ☐ Lung disease ☐ Joint disease/arthritis ☐ Cancer

6. Do you take any of the following medications daily:

☐ NSAID (e.g., aspirin, Iburpofen) ☐ Corticosteroids ☐ Antibiotics

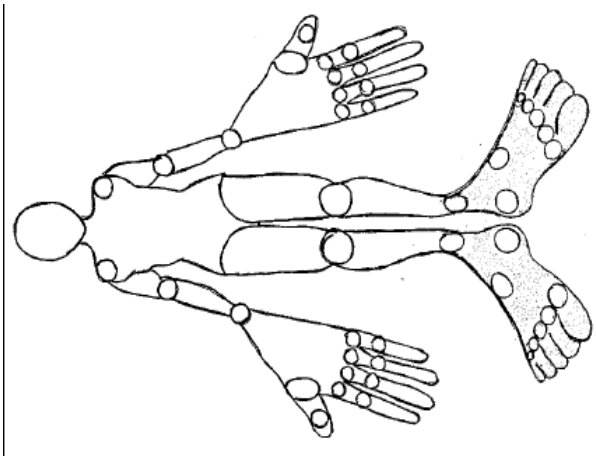
7. Have you experiencing any new illnesses in the past 3 months? ☐Yes ☐ No
(If more than one illness episode, detail each additional episode in Notes.)

7a. If yes, first day of illness (MM/DD/YYYY):_____/_____/_____

7b. What symptoms did you have (check all that apply)?

☐ Fever ☐ Chills ☐ Nausea/Vomiting ☐ Diarrhea
☐ Muscle pain ☐ Joint pain ☐ Skin rash ☐ Red eyes
☐ Headache ☐ Pain behind eyes ☐ Abdominal pain ☐ Cough
☐ Runny nose ☐ Sore throat ☐ Calf pain ☐ Arthritis (red, swollen joints)
☐ Minor bleeding (e.g., petechia, gum bleed, nosebleed, severe bruising)
☐ Major bleeding (e.g., vomiting blood, coughing up blood, blood in stool, heavy menses)

☐ 7b-1. If you had joint pain, indicate the locations where you had the pain



7c. How long did this illness last?_____days

7d. Did you go to the doctor because of this illness? ☐ Yes ☐ No

7d-1. If yes, Name of hospital/clinic:_____

7d-2. What was the diagnosis? ☐Chikungunya ☐ Dengue

☐ Viral syndrome ☐ I don't know ☐ Other: _____

7d-3. Were you hospitalized for this illness? ☐ Yes ☐ No

7d-3a. If yes, Hospital Name: _____

7d-3b. Days in the hospital:_____days

8. Have you used mosquito repellent in the past month? ☐ Daily ☐ Weekly ☐ Never

9. Have you slept under a bednet in the past month? ☐ Yes ☐ No

10. Have you traveled outside of Puerto Rico in the past 3 months? ☐ Yes ☐ No

10a. If yes, specify where and date of return to Puerto Rico for the most recent trip:

☐ United States (excluding USVI) ☐ Dominican Republic ☐Caribbean cruise

☐Other: _____

Date of return to PR (MM/DD/YYYY):_____/_____/_____

NOTES:

Estado Libre Asociado de Puerto Rico
Departamento de Salud

SISTEMA CENTINELA DE VIGILANCIA DE CHIKUNGUNYA (CHIKSS)
REPORTE DE CASO

Form Approved
OMB No. 0920-1011
Exp.: 3/31/2014

REVISADO: ☐ (iniciales)

Fecha de hoy: ___/___/___ Día Mes Año

FIEBRE + POLIARTRALGIA + NO TOS

SOLAMENTE PARA USO DEL LABORATORIO

Número de caso
SAN ID
GCODE

Espécimen #	Días después 1er síntoma	Tipo	Fecha recibido	Espécimen #	Días después 1er síntoma	Tipo	Fecha recibido
S1				S3			
S2				S4			

Favor de leer y completar TODAS las secciones

Datos del paciente

Se hospitalizó por esta enfermedad: ☐ No ☐ Sí → Nombre del hospital: Número de expediente:

Nombre del Paciente: _____
Apellido paterno | Apellido materno | Nombre | Segundo nombre / inicial

Si el paciente es un menor, nombre del padre o encargado: _____
Apellido paterno | Apellido materno | Nombre | Segundo nombre / inicial

Falleció: ☐ Sí ☐ No ☐ No sabe

Cambios en estado mental: ☐ Sí ☐ No ☐ No sabe

Dirección residencial completa (Física)

Dirección de la casa aquí

Municipio: Código postal:_____-_____

Tel.: Otro Tel.:

Vive cerca de:

Nombre y dirección del trabajo:

Médico o proveedor que ordenó la prueba de chikungunya

Nombre:

Hospital:

☐ Bella Vista ☐ HIMA Fajardo ☐ CDT San José
☐ Buen Samaritano ☐ San Jorge Children's
☐ HIMA Caguas ☐ Susoni

Información demográfica del paciente

Fecha nacimiento: Edad:_____meses Sexo: M F
___/_____/_____ ó Edad:_____años ¿Encinta?: Sí No NS
Día Mes Año
Semanas de gestación

¿Quién llenó este formulario?

☐ Doctor(a) ☐ Enfermero(a) ☐ OTRO_____

Datos indispensables para procesar las muestras

Día Mes Año

Fecha del primer síntoma: ___/___/___

Fecha de toma de muestra: ___/___/___

Datos adicionales del paciente

¿Cuántos años ha vivido en este municipio? _____

¿En qué país nació? _____

¿Durante los 14 días antes de enfermar, ¿VIAJÓ a otro país o pueblo?
☐ Sí, otro país ☐ Sí, otro pueblo ☐ No ☐ No sabe

¿A dónde viajó? _____

¿Desde que se enfermó, faltó a la escuela/trabajo?
☐ SI ☐ NO ☐ NO APLICA

POR FAVOR indique todos los signos y síntomas del paciente

	Sí	No	No sabe
Fiebre durante 2 – 7 días	☐	☐	☐
Fiebre (>38ºC/101ºF)	☐	☐	☐

Alguna manifestación hemorrágica

Petequias	☐	☐	☐
Equimosis o Cardenales	☐	☐	☐
Vómito con sangre	☐	☐	☐
Sangre en la excreta	☐	☐	☐
Hemorragia nasal	☐	☐	☐
Hemorragia de las encías	☐	☐	☐
Sangre en la orina	☐	☐	☐
Hemorragia vaginal	☐	☐	☐
Urianálisis positivo (sobre 5 RBC/hpf o positivo para sangre)	☐	☐	☐

Medidas Clínicas

Presión arterial (SBP/DBP) : _____/_____
Hematocrito (%): _____
Conteo de glóbulos blancos (WBC):_____Conteo de plaquetas: _____

Síntomas	Sí	No	No sabe
Pulso acelerado y débil	☐	☐	☐
Palidez o piel fría	☐	☐	☐
Erupción de la piel	☐	☐	☐
Dolor de cabeza	☐	☐	☐
Dolor en los ojos	☐	☐	☐
Dolor en el cuerpo	☐	☐	☐
Dolor de coyunturas	☐	☐	☐
Anorexia	☐	☐	☐

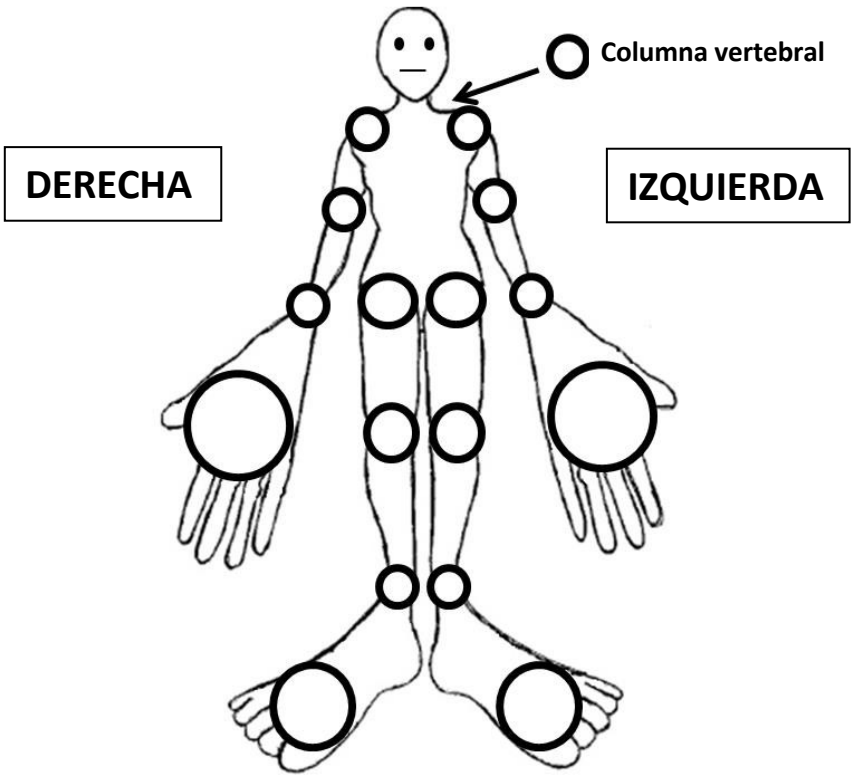
Señales de advertencia	Sí	No	No sabe
Vómito persistente	☐	☐	☐
Dolor abdominal/sensibilidad	☐	☐	☐
Sangrado de las mucosas	☐	☐	☐
Letargia/inquietud	☐	☐	☐
Agrandamiento del hígado > 2cm	☐	☐	☐
Efusión pleural o abdominal	☐	☐	☐

Síntomas adicionales

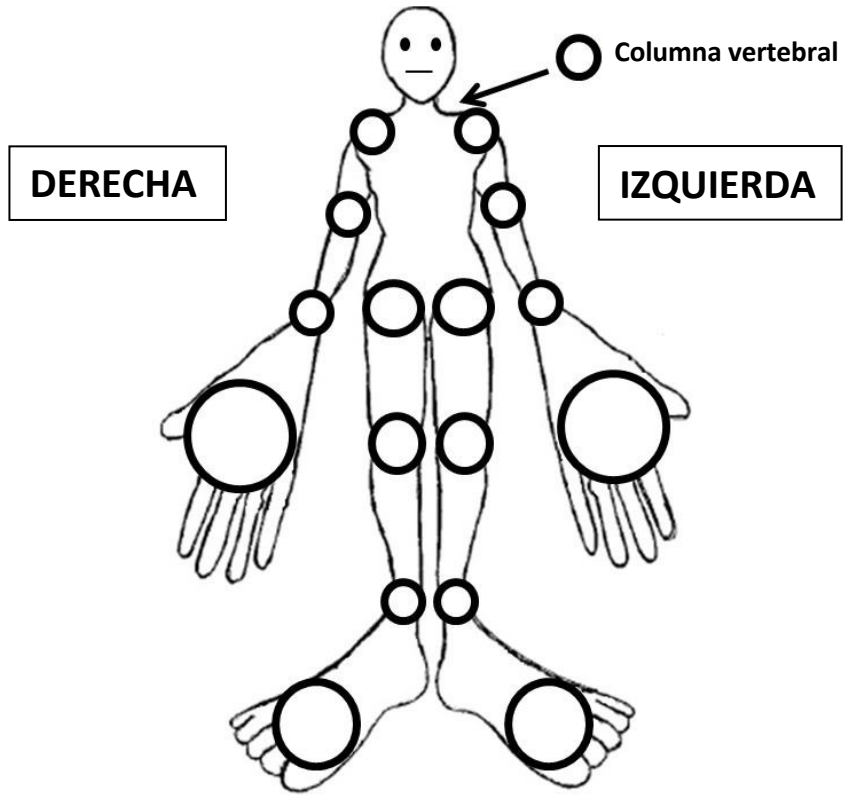
Diarrea	☐	☐	☐
Tos	☐	☐	☐
Conjuntivitis	☐	☐	☐
Congestión nasal	☐	☐	☐
Dolor de garganta	☐	☐	☐
Ictericia	☐	☐	☐
Convulsión o coma	☐	☐	☐
Náusea y vómito (ocasional)	☐	☐	☐
Artritis (coyunturas hinchadas)	☐	☐	☐
No puede caminar	☐	☐	☐

CONTINÚE AL DORSO!!

Los círculos a continuación representan las coyunturas en el cuerpo humano, marque con una “X” las áreas donde el paciente tiene **DOLOR**



Los círculos a continuación representan las coyunturas en el cuerpo humano, marque con una “X” las áreas donde el paciente tiene **LAS COYUNTURAS ROJAS E HINCHADAS**



ESPACIO PARA ETIQUETA DEL LABORATORIO

Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

Appendix 1:

VIRAL HEMORHAGIC FEVER
CASE INVESTIGATION FORM

VIRAL HEMORHAGIC 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: _____ Village/Town: _____ Parish: _____

Country of Residence: _____ District: _____ Sub-County: _____

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:

Village/Town: _____ District: _____ Sub-County: _____

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	☐ Yes ☐ No ☐ Unk
If yes, Temp: ____º 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

Unexplained bleeding from any site	☐ Yes ☐ No ☐ Unk
If Yes:	
Bleeding of the gums	☐ Yes ☐ No ☐ Unk
Bleeding from injection site	☐ Yes ☐ No ☐ Unk
Nose bleed (epistaxis)	☐ Yes ☐ No ☐ Unk
Bloody or black stools (melena)	☐ Yes ☐ No ☐ Unk
Fresh/red blood in vomit (hematemesis)	☐ Yes ☐ No ☐ Unk
Digested blood/"coffee grounds" in vomit	☐ Yes ☐ No ☐ Unk
Coughing up blood (hemoptysis)	☐ Yes ☐ No ☐ Unk
Bleeding from vagina, other than menstruation	☐ Yes ☐ No ☐ Unk
Bruising of the skin (petechiae/ecchymosis)	☐ Yes ☐ No ☐ Unk
Blood in urine (hematuria)	☐ Yes ☐ No ☐ Unk
Other hemorrhagic symptoms	☐ Yes ☐ No ☐ Unk
If yes, please specify: _____	

Other non-hemorrhagic clinical symptoms: ☐ Yes ☐ No ☐ Unk

If yes, please specifiy: _____

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: _____

Village/Town: _____ District: _____ Sub-County: _____

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	Village	District	Was the patient isolated?
___/___/____ - ___/___/____ (D, M, Yr)				☐ Yes ☐ No
___/___/____ - ___/___/____ (D, M, Yr)				☐ Yes ☐ 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)	Village	District	Was the person dead or alive ?	Contact Types**
		__/__/__ - __/__/__			☐ Alive ☐ Dead, date of death: __/__/____ (D, M, Y)	
		__/__/__ - __/__/__			☐ Alive ☐ Dead, date of death: __/__/____ (D, M, Y)	
		__/__/__ - __/__/__			☐ Alive ☐ 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)	Village	District	Did the patient participate (carry or touch the body)?
		__/__/____ - __/__/____			☐ Yes ☐ No
		__/__/____ - __/__/____			☐ Yes ☐ No

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

If yes, Village: _____ District: _____ 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: _____ Village: _____ District: _____

5. Did the patient consult a traditional/spiritual healer before becoming ill? ☐ Yes ☐ No ☐ Unk

If yes, Name of Healer: _____Village: _____ District: _____ 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):
☐ Bats or bat feces/urine	☐ Healthy ☐ Sick/Dead
☐ Primates (monkeys)	☐ Healthy ☐ Sick/Dead
☐ Rodents or rodent feces/urine	☐ Healthy ☐ Sick/Dead
☐ Pigs	☐ Healthy ☐ Sick/Dead
☐ Chickens or wild birds	☐ Healthy ☐ 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 UVRI 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 UVRI 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: _____ District: _____ 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: _____ District: _____
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: _____
Village: _____ District: _____ Sub-County: _____

Date of Funeral/Burial: ____/____/_____ (D, M, Yr) Funeral conducted by: ☐ Family/community ☐ Outbreak burial team
Place of Funeral/Burial:
Village: _____ District: _____ Sub-County: _____

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: ____º 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 specifiy: _____

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Appendix 2:

CONTACT TRACING FORM

GUINEA VIRAL HEMORRHAGIC FEVER CONTACT LISTING FORM

Case Information

UVRI/MoH Case ID	Surname	Other Names	Head of Household	Village	Sub-County	District	Date of Symptom Onset	Date of Admission to Isolation	Date of Death

***For all information on location, please list information on where the contact will be residing for the next month.*

Contact Information

Surname	Other Names	Sex (M/F)	Age (yrs)	Relation to Case	Date of Last Contact with Case	Type of Contact (1,2,3,4)* list all	Head of Household	Village	District	Sub-County	LC1 Chairman	Phone Number	Healthcare Worker (Y/N) *If yes,* what facility?

***Types of Contact:**

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

Contact Sheet Filled by: **Name:** _____ **Position:** _____ **Phone:** _____

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State: _____ Date reported to health department: ___/___/_____ (MM/DD/YYYY) Date interview completed: ___/___/_____ (MM/DD/YYYY)

Alien Number:_____ CDC Lab ID: _____

Demographic Information

1. Date of birth: _____/_____/_____ (MM/DD/YYYY)
2. Country of origin: _____ Region: _____ City/town: _____
3. Estimated travel time from country of origin to US border: _____ ☐days ☐weeks ☐months
4. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
5. Sex: ☐ Male ☐ Female

Symptoms and Care Seeking

6. What date did symptoms associated with this illness start? _____/_____/_____ (MM/DD/YYYY)
7. Were symptoms present at the CBP Processing Center? ☐ Yes ☐ No ☐ Unknown
8. Were symptoms present at a CBP facility before transfer to the processing center? ☐ Yes, which facility? _____ ☐No ☐Unknown
9. During this illness, did the patient experience any of the following?

Symptom	Symptom Present?	Symptom	Symptom Present?
Fever (highest temp _____ °F)	☐ Yes ☐ No ☐ Unk	Shortness of breath	☐ Yes ☐ No ☐ Unk
If fever present, date of onset ___/___/____ (MM/DD/YYYY)		Vomiting	☐ Yes ☐ No ☐ Unk
Felt feverish	☐ Yes ☐ No ☐ Unk	Diarrhea	☐ Yes ☐ No ☐ Unk
If felt feverish, date of onset ___/___/____ (MM/DD/YYYY)		Eye infection/redness	☐ Yes ☐ No ☐ Unk
Cough	☐ Yes ☐ No ☐ Unk	Rash	☐ Yes ☐ No ☐ Unk
Sore Throat	☐ Yes ☐ No ☐ Unk	Fatigue	☐ Yes ☐ No ☐ Unk
Muscle aches	☐ Yes ☐ No ☐ Unk	Seizures	☐ Yes ☐ No ☐ Unk
Headache	☐ Yes ☐ No ☐ Unk	Back pain	☐ Yes ☐ No ☐ Unk
Abdominal pain	☐ Yes ☐ No ☐ Unk	Other, specify	☐ Yes ☐ No ☐ Unk

10. Does the patient still have symptoms?
    ☐ Yes (skip to Q.12) ☐ No ☐ Unknown (skip to Q.12)
11. When did the patient feel back to normal? _____/_____/_____ (MM/DD/YYYY)
12. Did the patient receive any medical care for the illness?
    ☐ Yes ☐ No (skip to Q.14) ☐ Unknown (skip to Q.14)
13. Where and on what date did the patient seek care (check all that apply)?
    ☐ CBP Processing Center **date**:_____/_____/_____ (MM/DD/YYYY) ☐ Shelter medical service **date**:_____/_____/_____ (MM/DD/YYYY)
    ☐ Urgent care **date**:_____/_____/_____ (MM/DD/YYYY) ☐ Emergency room **date**:_____/_____/_____ (MM/DD/YYYY)
    ☐ Other _____ **date**:_____/_____/_____ (MM/DD/YYYY) ☐ Unknown
14. Did the patient experience any other complications as a result of this illness? ☐ Yes (please describe below) ☐ No ☐ Unknown
    _____
15. Does the patient have any preexisting medical conditions (e.g. problems with heart, lung)? ☐ Yes (please describe below) ☐ No ☐ Unknown
    _____

Risk Factors

16. In the 7 days prior to illness onset, please list the locations/CPB facilities the patient has been (including international).
    Location 1: Dates: _____/_____/_____ to _____/_____/_____ Country _____ State _____ City/CPB facility_____
    Location 2: Dates: _____/_____/_____ to _____/_____/_____ Country _____ State _____ City/CPB facility_____
    Location 3: Dates: _____/_____/_____ to _____/_____/_____ Country _____ State _____ City/CPB facility_____
17. Which dormitory was the patient in when symptomatic? _____ (dormitory 101-110)
18. Which bed number was the patient in when symptomatic? _____
19. Does the patient know anyone who had fever, respiratory symptoms like cough or sore throat, or another respiratory illness like pneumonia **in the 7 days BEFORE** the case patient's illness onset?
    ☐ Yes (**please list those ill before the case patient in the table below**) ☐ No ☐ Unknown

Contact name	Sex (M/F)	Age	Date of illness onset	Comments

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20. Any additional comments or notes?

_____

_____

_____

_____

_____

_____

Please review the patient's medical record, patient testing results, and facility records to obtain the answers for the remainder of the form.

Clinical Course, Treatment, and Outcome

21. Date of identification by CBP: _____/_____/_____ (MM/DD/YYYY)
22. Date of arrival to CBP Processing Center: _____/_____/_____ (MM/DD/YYYY) ☐ Nogales, AZ or ☐ McAllen, TX ☐ Other: _____
23. Date of arrival to Baytown Shelter: _____/_____/_____ (MM/DD/YYYY)
24. Approximately how many children were in the patient's dormitory at the shelter on the date of symptom onset? _____
25. Were other persons in the same dormitory symptomatic in the 7 days prior to the illness onset in this patient?
    ☐ Yes ☐ No (skip to Q.27) ☐ Unknown (skip to Q.27)
26. How many persons were ill? _____
27. Was the patient hospitalized for the illness?
    ☐ Yes ☐ No (skip to Q.36) ☐ Unknown (skip to Q.36)
28. Date(s) of hospital admission? **First admission date:**___/___/____ (MM/DD/YYYY) **Second admission date:**___/___/____ (MM/DD/YYYY)
29. Was the patient admitted to an intensive care unit (ICU)?
    ☐ Yes ☐ No (skip to Q.31) ☐ Unknown (skip to Q.31)
30. Date of **ICU admission:** _____/_____/_____ (MM/DD/YYYY) Date of **ICU discharge:** _____/_____/_____ (MM/DD/YYYY)
31. Did the patient receive mechanical ventilation / have a breathing tube?
    ☐ Yes ☐ No (skip to Q.33) ☐ Unknown (skip to Q.33)
32. For how many days did the patient receive mechanical ventilation or have a breathing tube? _____ days
33. Was the patient discharged?
    ☐ Yes ☐ No (skip to Q.36) ☐ Unknown (skip to Q.36)
34. Date(s) of hospital discharge? **First discharge date:**___/___/____ (MM/DD/YYYY) **Second discharge date:**___/___/____ (MM/DD/YYYY)
35. Where was the patient discharged?
    ☐ NBVC Shelter ☐ Family member ☐ Permanent shelter ☐ Other _____ ☐ Unknown
36. Did the patient have a new abnormality on chest x-ray or CAT scan?
    ☐ No, x-ray or scan was normal ☐ Yes, x-ray or scan detected new abnormality ☐ No, chest x-ray or CAT scan not performed ☐ Unknown
37. Did the patient receive a diagnosis of pneumonia?
    ☐ Yes ☐ No ☐ Unknown
38. Did the patient receive a diagnosis of ARDS?
    ☐ Yes ☐ No ☐ Unknown
39. Did the patient receive antimicrobials prior to becoming ill (within 2 weeks) or after becoming ill?
    ☐ Yes, (please complete table below) ☐ No ☐ Unknown

Drug	Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)	Total number of days receiving antivirals	Dosage (if known)
Oseltamivir (Tamiflu)				mg
Zanamivir (Relenza)				mg
Azithromycin				mg
Levofloxacin				mg
Augmentin				mg
Penicillin				mg
Other antimicrobial_____				mg
Other antimicrobial_____				mg
Other antimicrobial_____				mg

40. Did the patient die as a result of this illness?
    ☐ Yes, **Date of death**:_____/_____/_____ (MM/DD/YYYY) ☐ No ☐ Unknown

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Medical History -- Past Medical History and Vaccination Status

41. Were any of the following chronic medical conditions noted during patient interview or recorded on the patient's medical record? Please specify **ALL** conditions noted.

a.	Asthma/reactive airway disease	☐ Yes	☐ No	☐ Unknown	
b.	Tuberculosis	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
c.	Other chronic lung disease	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
d.	Chronic heart or circulatory disease	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
e.	Diabetes mellitus	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
f.	Kidney or renal disease	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
g.	Non-cancer immunosuppressive condition	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
h.	Cancer chemotherapy in past 12 months	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
i.	Neurologic/neurodevelopmental disorder	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
j.	Cerebrospinal fluid leaks	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
k.	Chronic liver disease	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
l.	Sickle cell/other hemaglobinopathies	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
m.	Congenital or acquired asplenia	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
n.	Malnutrition	☐ Yes	☐ No	☐ Unknown	(If YES, specify weight/height) _____
o.	Other chronic diseases	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____

42. Was patient pregnant or ≤6 weeks postpartum at illness onset?
☐ Yes, pregnant (weeks pregnant at onset)_____ ☐Yes, postpartum (delivery date) ___/___/____ (MM/DD/YYYY) ☐ No ☐ Unknown
43. Does the patient currently smoke?
☐ Yes ☐ No ☐ Unknown
44. Was the patient vaccinated against influenza in the past year?
☐ Yes ☐ No (skip to Q.47) ☐ Unknown (skip to Q.47)
45. Month and year of influenza vaccination? **Vaccination date 1:**____/_____ (MM/YYYY) **Vaccination date 2:**____/_____ (MM/YYYY)
46. Type of influenza vaccine (check all that apply): ☐ Inactivated (injection) ☐ Live attenuated (nasal spray) ☐ Unknown
47. Did the patient ever receive the pneumococcal vaccine?
☐ Yes ☐ No (skip to Q.49) ☐ Unknown (skip to Q.49)
48. Month and year of pneumococcal vaccination? **Vaccination date 1:**____/_____ (MM/YYYY)

Specimen Testing Results

49. Was the patient tested for any pathogens? ☐ Yes (please complete table below) ☐ No ☐ Unknown

	Positive	Negative	Not Tested/Unknown	Collection Date	CT Value
a. Influenza	☐	☐	☐	____/____/_____	_____
If influenza positive, specify subtype	☐ H1N1pdm09 ☐ H3N2 ☐ A,subtype unknown ☐ Influenza B ☐ Other_____ ☐ Unknown				
b. Pneumococcus	☐	☐	☐	____/____/_____	_____
c. Respiratory syncytial virus/RSV	☐	☐	☐	____/____/_____	_____
d. Adenovirus	☐	☐	☐	____/____/_____	_____
e. Parainfluenza 1	☐	☐	☐	____/____/_____	_____
f. Parainfluenza 2	☐	☐	☐	____/____/_____	_____
g. Parainfluenza 3	☐	☐	☐	____/____/_____	_____
h. Human metapneumovirus	☐	☐	☐	____/____/_____	_____
i. Rhinovirus	☐	☐	☐	____/____/_____	_____
j. Coronavirus	☐	☐	☐	____/____/_____	_____
k. Other, specify: _____	☐	☐	☐	____/____/_____	_____
l. Other, specify: _____	☐	☐	☐	____/____/_____	_____
m. Other, specify: _____	☐	☐	☐	____/____/_____	_____

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Estado: _TX_ Fecha de reporte al Departamento de Salud: ___/___/___ (MM/DD/AAAA) Fecha de la entrevista: ___/___/_____ (MM/DD/AAAA)

Número de extranjería:_____ CDC Lab ID: _____

Información Demográfica

1. Fecha de nacimiento: _____/_____/_____ (MM/DD/AAAA)
2. País de origen: _____Region:_____Ciudad/Pueblo:_____
3. Tiempo de viaje estimado de país de origen a la frontera con EEUU: _____ ☐días ☐semanas ☐meses
4. Etnia: ☐ Hispano ó Latino ☐ No Hispano ó Latino
5. Sexo: ☐ Masculino ☐ Femenino

Síntomas, Curso Clínico de la enfermedad, Tratamiento, Análisis de las muestras y Resultados

6. En qué fecha comenzaron los síntomas asociados con la enfermedad? _____/_____/_____ (MM/DD/AAAA) (VER CALENDARIO)
7. Los síntomas estaban presentes al llegar a la Base de la Patrulla de Frontera de los EEUU? ☐ Si ☐ No ☐ No sabe
8. Los síntomas estaban presentes antes de llegar a la Base de la Patrulla de Frontera de los EEUU? ☐ Si ☐ No ☐ No sabe, si dijo si Cual?_____
9. Durante el curso de la enfermedad, el paciente manifestó alguno de los siguientes síntomas?

Síntoma	**Presentó?**	**Síntoma**	**Presentó?**
Fiebre (Temperatura más alta __ °F)	☐ Si ☐ No ☐ No sabe	Dificultad para respirar	☐ Si ☐ No ☐ No sabe
Si presentó fiebre, fecha de inicio __/__/___(MM/DD/AAAA)		Vómitos	☐ Si ☐ No ☐ No sabe
Se sintió afiebrado	☐ Si ☐ No ☐ No sabe	Diarrea	☐ Si ☐ No ☐ No sabe
Si se sintió afiebrado, fecha de inicio__/__/__(MM/DD/AAAA)		Infección en los ojos/Ojos rojos	☐ Si ☐ No ☐ No sabe
Tos	☐ Si ☐ No ☐ No sabe	Salpullido	☐ Si ☐ No ☐ No sabe
Dolor de garganta	☐ Si ☐ No ☐ No sabe	Fatiga	☐ Si ☐ No ☐ No sabe
Dolor muscular ó de cuerpo	☐ Si ☐ No ☐ No sabe	Convulsiones	☐ Si ☐ No ☐ No sabe
Dolor de cabeza	☐ Si ☐ No ☐ No sabe	Dolor de espalda	☐ Si ☐ No ☐ No sabe
Dolor abdominal	☐ Si ☐ No ☐ No sabe	Otro, especificar	☐ Si ☐ No ☐ No sabe

10. El paciente todavía tiene síntomas?

☐ Si (Pasar a la pregunta Q.12) ☐ No ☐ No sabe (Pasar a la pregunta Q.12)

11. En qué fecha es que el paciente se siente sano nuevamente? _____/_____/_____ (MM/DD/AAAA)
12. Recibió el paciente la atención médica adecuada para tratar la enfermedad?

☐ Si ☐ No (Pasar a la pregunta Q.14) ☐ No sabe (Pasar a la pregunta Q.14)

13. Dónde y en qué fecha es que el paciente solicita atención médica (marcar todas las que apliquen)?

☐ Base de la Patrulla de Frontera de los EEUU **fecha**:_____/_____/_____ (MM/DD/AAAA)
☐ Clínica de CASA HOGAR **fecha**:_____/_____/_____ (MM/DD/AAAA)
☐ Clínica de urgencia **fecha**:_____/_____/_____ (MM/DD/AAAA)
☐ Sala de emergencia **fecha**:_____/_____/_____ (MM/DD/AAAA)
☐ Otro, especificar _____ **fecha**:_____/_____/_____ (MM/DD/AAAA) ☐ No sabe

14. El paciente desarrolló alguna complicación como resultado de la enfermedad? ☐ Si (por favor describir/especificar) ☐ No ☐ No sabe

_____

15. El paciente tenía alguna condición médica preexistente (por ejemplo condición crónica pulmonar) ☐ Si (por favor describir/especificar) ☐ No ☐ No sabe

_____

Factores de Riesgo

16. En los 7 días previos al inicio de síntomas, liste la ubicación del paciente (incluyendo zona internacional)

Ubicación 1: Fecha: De_____/____/_____a _____/_____/____ País _____Estado _____Ciudad/Base Patrulla Fronteriza_____
Ubicación 2: Fecha: De_____/____/____ a _____/_____/____ País _____ Estado _____ Ciudad/Base Patrulla Fronteriza_____
Ubicación 3: Fecha: De_____/____/____ a _____/_____/____ País _____ Estado _____ Ciudad/Base Patrulla Fronteriza_____
Ubicación 4: Fecha: De_____/____/_____a _____/_____/____ País _____Estado _____ Ciudad/Base Patrulla Fronteriza_____

17. En qué numero de dormitorio se encontraba el paciente cuando tuvo los síntomas? _____ (dormitorio 101-110)
18. En qué numero de cama se encontraba el paciente cuando tuvo los síntomas? _____

19. El paciente conoció a alguien que tuvo fiebre, síntomas respiratorio como tos o dolor de garganta u otro síntoma respiratorio como neumonía **7 días ANTES** del inicio de síntomas en el paciente?

☐ Si (**liste todos los que estuvieron enfermos antes que el paciente**) ☐ No ☐ No sabe

Nombre	Sexo (M/F)	Edad	Fecha de inicio de síntomas	Comentarios

20. Algún comentario o nota adicional?

_____

_____

_____

_____

_____

_____

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Hospitalized Case Investigation Form
Respiratory Illness

UAC Respiratory Disease Cluster
Hospitalization Case Investigation Form

Alien Number _____

I. Reporter Information

State/Territory_____ State/Territory Epi Case ID_____ State/Territory Lab ID _____

Date form completed:____/____/_____ CDC Case ID _____

Person completing form: First Name:_____Last Name:_____Phone:_____ Email:_____

What are the source(s) of data for this report? (check all that apply) ☐ Medical chart ☐ Death certificate ☐ Case report form ☐ Other_____

II. Patient Information and Medical Care

1. Patient Date of birth:____/____/_____(mm/dd/yyyy)

2. Did the patient have an outpatient or ER medical care encounter during this illness? ☐ Yes, date:____/___/_____ ☐ No ☐ Unknown (if multiple, list most recent)

3. Was the patient admitted to the hospital for this illness? ☐ Yes, date:____/___/_____ ☐ No ☐ Unknown Time:____:____☐ AM ☐ PM

4. Was patient hospitalized previously at another facility during this illness? ☐ Yes ☐ No ☐ Unknown

Admission date:____/____/_____ Discharge date:____/____/_____ Was discharge from prior hospital a transfer? ☐ Yes ☐ No

Please note initial vital signs at hospital admission/ER presentation. Date taken:____/___/_____(mm/dd/yyyy)

5. Body Mass **6.** Height ☐ Inches ☐ Height **7.** Weight: ☐ Lbs. ☐ Weight Unknown

8. Blood Pressure_____/_____ **9.** Respiratory Rate_____per min **10.** Heart Rate_____beats/min Temperature:_____☐°C ☐°F

11. O_2 Sat_____% **12.** Fraction of inspired oxygen_____☐ % ☐ L **13.** Using: ☐ O_2 mask ☐ room air ☐ ventilator Specify O_2 mask type:

III. Illness Signs and Symptoms

14. Please mark all signs and symptoms experienced or listed in the admission note. Date of initial symptom onset:____/____/_____

☐ Fever (measured) highest temp._____☐°C ☐°F Date of fever onset____/___/_____(mm/dd/yyyy)
☐ Feverishness (temperature not measured)
☐ Cough
☐ With sputum (i.e., productive)
☐ Hemoptysis or bloody sputum
☐ Sore throat
☐ Runny nose (rhinorrhea)
☐ Dyspnea/difficulty breathing
☐ Chest pain
☐ Wheezing
☐ Chills
☐ Headache
☐ Excessive crying/fussiness (< 5 years old)
☐ Fatigue/weakness
☐ Muscle pain/myalgia
Location_____
☐ Seizure
☐ Altered mental status
☐ Red or draining eyes (conjunctivitis)
☐ Abdominal pain
☐ Vomiting
☐ Diarrhea
☐ Rash, location _____
☐ Other_____

IV. Patient Medical History

15. Does the patient have any of the following pre-existing medical conditions? Check all that apply.

15a. ☐ **Asthma/Reactive Airway Disease**

15b. ☐ **Chronic Lung Disease**
☐ Emphysema/COPD
☐ Other:_____

15c. ☐ **Chronic Metabolic Disease**
☐ Diabetes
Insulin dependent ☐ Yes ☐ No ☐ Unknown
☐ Other:_____

15d. ☐ **Blood disorders/Hemoglobinopathy**
☐ Sickle cell disease
☐ Splenectomy/Asplenia
☐ Other:_____

15h. ☐ **Immunocompromising Condition**
☐ HIV infection
☐ AIDS or CD4 count < 200
☐ Stem cell transplant (e.g., bone marrow transplant)
☐ Organ transplant
☐ Cancer diagnosis within last 12 months (excluding non-melanoma skin cancer) Type:_____
☐ Chemotherapy within last 12 months
☐ Primary immune deficiency
☐ Chronic steroid therapy (within 2 weeks of admission)
☐ Other: _____

15i. ☐ **Renal Disease**
☐ Chronic kidney disease/chronic renal insufficiency
☐ End stage renal disease
☐ Dialysis
☐ Nephrotic syndrome
☐ Other:_____

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15e. ☐ **Cardiovascular Disease (excluding hypertension)**
- ☐ Atherosclerotic cardiovascular disease
- ☐ Cerebral vascular incident/Stroke
  With disability ☐ Yes ☐ No ☐ Unknown
- ☐ Congenital heart disease
- ☐ Coronary artery disease (CAD)
- ☐ Heart failure/Congestive heart failure
- ☐ Other:_____

15f. ☐ **Neuromuscular or Neurologic disorder**
- ☐ Muscular dystrophy
- ☐ Multiple sclerosis
- ☐ Mitochondrial disorder
- ☐ Myasthenia gravis
- ☐ Cerebral palsy
- ☐ Dementia
- ☐ Severe developmental delay
- ☐ Plegias/Paralysis
- ☐ Epilepsy/Seizure disorder
- ☐ Other:_____

15g. ☐ **History of Guillain-Barré Syndrome**

15j. ☐ **Other**
- ☐ Liver disease
- ☐ Scoliosis
- ☐ Obese or BMI ≥ 30
- ☐ Morbidly obese or BMI ≥ 40
- ☐ Down syndrome
- ☐ Pregnant, gestational age in weeks:_____ ☐ Unknown
- ☐ Post-partum (≤ 6 weeks)
- ☐ Current smoker
- ☐ Drug abuse
- ☐ Alcohol abuse
- ☐ Other:_____

PEDIATRIC CASES ONLY (<18 years old)

Abnormality of upper airway	☐ Yes	☐ No	☐ Unknown
History of febrile seizures	☐ Yes	☐ No	☐ Unknown
Premature	☐ Yes	☐ No	☐ Unknown

(gestational age < 37 weeks at birth for patients < 2yrs)
If yes, specify gestation age at birth in weeks: _____
☐ Unknown gestational age at birth

V. Hematology and Serum Chemistries

16. Were any hematology or serum chemistries performed at hospital admission/presentation to care? ☐ Yes ☐ No (skip to Q. 35) ☐ Unknown (skip to Q. 35)

Please note initial values at admission/presentation to care. Date values were taken:____/___/____(mm/dd/yyyy)

17. White blood cell count (WBC)	cells/mm^3	**19.** Hematocrit (Hct)	%	**24.** Serum creatinine	mg/dL
18. Differential: Neutrophils	%	**20.** Platelets (Plt)	10^3/mm^3	**25.** Serum glucose	mg/dL
Bands	%	**21.** Sodium (Na)	U/L	**26.** SGPT/ALT	U/L
Lymphocytes	%	**21.** Potassium (K)	U/L	**27.** SGOT/AST	U/L
Eosinophils	%	**22.** Bicarbonate (HCO_3)	U/L	**28.** Total bilirubin	mg/dL
		23. Serum albumin	g/dL	**29.** C-reactive protein (CRP)	mg/dL

Please describe other significant lab findings (e.g., CSF, protein).

	Type of test	Specimen type	Date (mm/dd/yyyy)	Result
31.			/ /	
32.			/ /	
33.			/ /	
34.			/ /	

VI. Bacterial Pathogens – *Sterile or respiratory site only*

35. Was a pneumococcal urinary antigen test performed? ☐ Yes ☐ No ☐ Unknown
If yes, result: ☐ Positive ☐ Negative ☐ Unknown

35. Was a *Legionella* urinary antigen test performed? ☐ Yes ☐ No ☐ Unknown
If yes, result: ☐ Positive ☐ Negative ☐ Unknown

35. Were any bacterial culture tests performed (regardless of result)? ☐ Yes ☐ No (skip to Q.41) ☐ Unknown (skip to Q.41)

36. . Indicate sites from which specimens were collected (check all that apply): ☐ Blood ☐ Cerebrospinal fluid (CSF) ☐ Bronchoalveolar lavage (BAL) ☐ Sputum ☐ Pleural fluid ☐ Endotracheal aspirate ☐ Other:_____

37. Was there culture confirmation of any bacterial infection? ☐ Yes ☐ No (skip to Q.41) ☐ Unknown (skip to Q.41)

38a. Positive Culture 1 collection date: ____/____/_____(mm/dd/yyyy)
38b. Specimen type: ☐ Blood ☐ Cerebrospinal fluid (CSF) ☐ Bronchoalveolar lavage (BAL) ☐ Sputum ☐ Pleural fluid ☐ Endotracheal aspirate ☐ Other:____
38c. Pathogen(s) identified: ☐ *S. aureus* ☐ *S. pyogenes* ☐ *S. pneumoniae* ☐ *H. influenzae* ☐ Other:____
38d. If *Staphylococcus aureus*, specify: ☐ Methicillin resistant (MRSA) ☐ Methicillin sensitive (MSSA) ☐ Sensitivity unknown

39a. Positive Culture 2 collection date: ____/____/_____(mm/dd/yyyy)
39b. Specimen type: ☐ Blood ☐ Cerebrospinal fluid (CSF) ☐ Bronchoalveolar lavage (BAL) ☐ Sputum ☐ Pleural fluid ☐ Endotracheal aspirate ☐ Other:____
39c. Pathogen(s) identified: ☐ *S. aureus* ☐ *S. pyogenes* ☐ *S. pneumoniae* ☐ *H. influenzae* ☐ Other:____
39d. If *Staphylococcus aureus*, specify: ☐ Methicillin resistant (MRSA) ☐ Methicillin sensitive (MSSA) ☐ Sensitivity unknown

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40a. Positive Culture 3 collection date: ____/____/_____(mm/dd/yyyy) **40b. Specimen type:** ☐ Blood ☐ Cerebrospinal fluid (CSF) ☐ Bronchoalveolar lavage (BAL) ☐ Sputum ☐ Pleural fluid ☐ Endotracheal aspirate ☐ Other:____

40c. Pathogen(s) identified: ☐ *S. aureus* ☐ *S. pyogenes* ☐ *S. pneumoniae* ☐ *H. influenzae* Other:____

40d. If *Staphylococcus aureus*, specify: ☐ Methicillin resistant (MRSA) ☐ Methicillin sensitive (MSSA) ☐ Sensitivity unknown

VII. Respiratory Viral Pathogens

41. Was the patient tested for any other viral pathogens? ☐ Yes ☐ No (skip to Q.42) ☐ Unknown (skip to Q.42)

	Positive	Negative	Not Tested/Unknown	Collection Date	Specimen Type
a. Respiratory syncytial virus/RSV	☐	☐	☐	__/__/__	
b. Adenovirus	☐	☐	☐	__/__/__	
c. Parainfluenza 1	☐	☐	☐	__/__/__	
d. Parainfluenza 2	☐	☐	☐	__/__/__	
e. Parainfluenza 3	☐	☐	☐	__/__/__	
f. Human metapneumovirus	☐	☐	☐	__/__/__	
g. Rhinovirus	☐	☐	☐	__/__/__	
h. Coronavirus	☐	☐	☐	__/__/__	
i. Other, specify:_____	☐	☐	☐	__/__/__	
j. Other, specify:_____	☐	☐	☐	__/__/__	

VIII. Medications

42. Did the patient receive influenza antiviral medications during illness? ☐ **Yes** ☐ **No** ☐ **Unknown**

		Date started	Date stopped	Frequency	Dose
Oseltamivir (Tamiflu)	☐ PO ☐ IV ☐ Inhaled	__/__/__	__/__/__	☐ QD ☐ BID ☐ TID	
Zanamivir (Relenza)	☐ PO ☐ IV ☐ Inhaled	__/__/__	__/__/__	☐ QD ☐ BID ☐ TID	
Peramivir	☐ PO ☐ IV ☐ Inhaled	__/__/__	__/__/__	☐ QD ☐ BID ☐ TID	
Other influenza antiviral:_____	☐ PO ☐ IV ☐ Inhaled	__/__/__	__/__/__	☐ QD ☐ BID ☐ TID	
Other influenza antiviral:_____	☐ PO ☐ IV ☐ Inhaled	__/__/__	__/__/__	☐ QD ☐ BID ☐ TID	

43. Did the patient receive antibiotics during the illness? ☐ **Yes** ☐ **No** ☐ **Unknown**

If yes, name		Date started	Date stopped	Dose
	☐ PO ☐ IV ☐ IM	__/__/__	__/__/__	
	☐ PO ☐ IV ☐ IM	__/__/__	__/__/__	
	☐ PO ☐ IV ☐ IM	__/__/__	__/__/__	
	☐ PO ☐ IV ☐ IM	__/__/__	__/__/__	
	☐ PO ☐ IV ☐ IM	__/__/__	__/__/__	

44. Did the patient receive steroids (excluding inhaled steroids or one time injections) or other immune modulating treatment specifically for this illness? ☐ **Yes** ☐ **No** ☐ **Unknown**

If yes, name		Date started	Date stopped	Dose
	☐ PO ☐ IV ☐ IM	__/__/__	__/__/__	
	☐ PO ☐ IV ☐ IM	__/__/__	__/__/__	
	☐ PO ☐ IV ☐ IM	__/__/__	__/__/__	

45. Additional treatment comments:

IX. Chest Radiograph – *Based on final impression/conclusion of the radiology report*
Please include a copy of the radiology report with the form.

46. Did the patient have a chest x-ray *within 3 days* of admission? ☐ Yes, date____/___/_____ ☐ No (skip to Q.52) ☐ Unknown (skip to Q.52)

47. If yes, was the chest x-ray abnormal? ☐ Yes, date____/___/_____ ☐ No (skip to Q.52) ☐ Unknown (skip to Q.52)

48. For the abnormal chest x-ray, please transcribe the final impression/conclusion and check all that apply:

Final impression/conclusion:

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☐ **Consolidation:** →	☐ Single lobar infiltrate ☐ Lobar or segmental collapse	☐ Multi-lobar infiltrate (unilateral) ☐ Cavitation/Abscess/Necrosis	☐ Multi-lobar infiltrate (bilateral) ☐ Round pneumonia
☐ **Other Infiltrate:** →	☐ Alveolar (air space) disease	☐ Interstitial disease	☐ Mixed (airspace and interstitial) disease
☐ **Pleural Effusion:** →	☐ Unilateral	☐ Bilateral	
☐ **Bronchiolitis:** →	☐ Complicated	☐ Uncomplicated	
☐ **Other:** →	☐ Air leak/Pneumothorax ☐ Specify:_	☐ Lymphadenopathy	☐ Chest wall invasion

49. Did the patient have another chest x-ray *within 3 days of admission?* ☐ Yes, date____/____/_____ ☐ No (skip to Q.52) ☐ Unknown (skip to Q.52)

50. If yes, was the chest x-ray abnormal? ☐ Yes, date____/____/_____ ☐ No (skip to Q.52) ☐ Unknown (skip to Q.52)

51. For the abnormal chest x-ray, please transcribe the final impression/conclusion and check all that apply:

Final impression/conclusion:

☐ **Consolidation:** →	☐ Single lobar infiltrate ☐ Lobar or segmental collapse	☐ Multi-lobar infiltrate (unilateral) ☐ Cavitation/Abscess/Necrosis	☐ Multi-lobar infiltrate (bilateral) ☐ Round pneumonia
☐ **Other Infiltrate:** →	☐ Alveolar (air space) disease	☐ Interstitial disease	☐ Mixed (airspace and interstitial) disease
☐ **Pleural Effusion:** →	☐ Unilateral	☐ Bilateral	
☐ **Bronchiolitis:** →	☐ Complicated	☐ Uncomplicated	
☐ **Other:** →	☐ Air leak/Pneumothorax ☐ Specify:_____	☐ Lymphadenopathy	☐ Chest wall invasion

X. Chest CT or MRI – *Based on final impression/conclusion of the radiology report please include a copy of the radiology report with the form.*

52. Did the patient have a chest CT/MRI scan *within 3 days of admission?* ☐ Yes, date____/____/_____ ☐ No (skip to Q.56) ☐ Unknown (skip to Q.56)

52. If yes, please select one: ☐ CT: contrast ☐ CT: non-contrast ☐ MRI

54. If yes, was the CT/MRI abnormal? ☐ Yes, date____/____/_____ ☐ No (skip to Q.56) ☐ Unknown (skip to Q.56)

55. For abnormal chest CT/ MRI, please check all that apply and please transcribe the final impression/conclusion:

Final impression/conclusion:

☐ **Consolidation:** →	☐ Single lobar infiltrate ☐ Lobar or segmental collapse	☐ Multi-lobar infiltrate (unilateral) ☐ Cavitation/Abscess/Necrosis	☐ Multi-lobar infiltrate (bilateral) ☐ Round pneumonia
☐ **Other Infiltrate:** →	☐ Alveolar (air space) disease	☐ Interstitial disease	☐ Mixed (airspace and interstitial) disease
☐ **Pleural Effusion:** →	☐ Unilateral	☐ Bilateral	
☐ **Bronchiolitis:** →	☐ Complicated	☐ Uncomplicated	
☐ **Other:** →	☐ Air leak/Pneumothorax ☐ Specify:_____	☐ Lymphadenopathy	☐ Chest wall invasion

XI. Clinical Course and Severity of Illness

56. At any time during the current illness, did the patient require or have the diagnosis of :

a. Admission to intensive care unit (ICU) ☐ Yes ☐ No ☐ Unknown

Admission date: ____/____/_____ Discharge date: ____/____/_____

If multiple admissions, 2nd ICU admission date: ____/____/_____ 2nd ICU discharge date: ____/____/_____

If more than 2 ICU admissions, please provide dates in the comments section (Q.66)

b. Supplemental oxygen ☐ Yes ☐ No ☐ Unknown

Date started: ____/____/_____ Date stopped ____/____/_____

c. Ventilatory support ☐ Yes ☐ No ☐ Unknown

Check all that apply:

☐ Intubation	Date started: ____/____/_____	Date stopped: ____/____/_____
☐ ECMO	Date started: ____/____/_____	Date stopped: ____/____/_____
☐ CPAP	Date started: ____/____/_____	Date stopped: ____/____/_____

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☐ BiPAP Date started: ___/___/_____ Date stopped: ___/___/_____

d. Vasopressor medications (e.g. dopamine, epinephrine) Date started: / /	☐ Yes Date stopped / /	☐ No	☐ Unknown
e. Dialysis (Acute) Date started: / /	☐ Yes Date stopped / /	☐ No	☐ Unknown
f. Resuscitation, CPR	☐ Yes, date started: ___/___/_____ stopped: / /	☐ No	☐ Unknown
g. Acute respiratory distress syndrome (ARDS)	☐ Yes, date started: ___/___/_____ stopped: / /	☐ No	☐ Unknown
h. Disseminated intravascular coagulopathy (DIC)	☐ Yes, date started: ___/___/_____ stopped: ___/___/_____	☐ No	☐ Unknown
i. Hemophagocytic syndrome	☐ Yes, date started: ___/___/_____ stopped: /_ /_____	☐ No	☐ Unknown
j. Bronchiolitis	☐ Yes, date started: ___/___/_____ stopped: /_ /_____	☐ No	☐ Unknown
k. Pneumonia	☐ Yes, date started: ___/___/_____ stopped: /_ /_____	☐ No	☐ Unknown
l. Stroke (Acute)	☐ Yes, date started: ___/___/_____ stopped: /_ /_____	☐ No	☐ Unknown
m. Sepsis	☐ Yes, date started: ___/___/_____ stopped: /_ /_____	☐ No	☐ Unknown
n. Shock Type: ☐ hypovolemic ☐ cardiogenic ☐ septic ☐ toxic	☐ Yes, date started: ___/___/_____ stopped: /_ /_____	☐ No	☐ Unknown
o. Acute myocarditis	☐ Yes, date started: ___/___/_____ stopped: ___/_ /_____	☐ No	☐ Unknown
p. Acute myocardial dysfunction	☐ Yes, date started: ___/___/_____ stopped: ___/_ /_____	☐ No	☐ Unknown
q. Acute myocardial infarction	☐ Yes, date started: ___/___/_____ stopped: ___/_ /_____	☐ No	☐ Unknown
r. Seizures	☐ Yes, date started: ___/___/_____ stopped: ___/_ /_____	☐ No	☐ Unknown
s. Reye's syndrome	☐ Yes, date started: ___/___/_____ stopped: ___/_ /_____	☐ No	☐ Unknown
t. Acute encephalitis / encephalopathy	☐ Yes, date started: ___/___/_____ stopped: ___/_ /_____	☐ No	☐ Unknown
u. Guillain-Barre syndrome	☐ Yes, date started: ___/___/_____ stopped: ___/_ /_____	☐ No	☐ Unknown
v. Rhabdomyolysis	☐ Yes, date started: ___/___/_____ stopped: ___/_ /_____	☐ No	☐ Unknown
w. Acute liver impairment	☐ Yes, date started: ___/___/_____ stopped: ___/_ /_____	☐ No	☐ Unknown
x. Acute renal failure	☐ Yes, date started: ___/___/_____ stopped: ___/_ /_____	☐ No	☐ Unknown
y. Other, specify: _____	☐ Yes, date started: ___/___/_____ stopped: ___/_ /_____		
z. Other, specify: _____	☐ Yes, date started: ___/___/_____ stopped: ___/_ /_____		

XII. Outcomes

57. Did the patient die during this illness? ☐ Yes, date_____/_____/_____ ☐ No (skip to Q.62) ☐ Unknown (skip to Q.62)

58. What was the location of death? ☐ Home ☐ Hospital ☐ ER ☐ Hospice ☐ Other, specify_____

59. . Did the patient have a DNR (do not resuscitate) order? ☐ Yes ☐ No ☐ Unknown

60. Was an autopsy performed? ☐ Yes (please attach a copy of the autopsy form to this report if available) ☐ No ☐ Unknown

61. What were the causes of death (immediate and underlying) in order of appearance on the death certificate or medical record?

1.	4.	7.
2.	5.	8.
3.	6.	9.

62. Has the patient been discharged from the hospital? ☐ Yes, date____/_____/_____ ☐ No ☐ Unknown

63. If yes, please indicate to where: ☐ Home ☐ Other hospital ☐ Hospice ☐ Rehabilitation Facility ☐ Other long-term care facility ☐ Other, specify:_____ ☐ Unknown

63. If no, please indicate status: ☐ Hospitalized on ward ☐ Hospitalized in ICU ☐ Died

64. If patient was pregnant, please indicate pregnancy status at discharge or final update:

☐ Still pregnant ☐ Uncomplicated labor/delivery ☐ Complicated labor/delivery Describe_____ ☐ Fetal loss Date____/___/_____

64. If pregnancy resulted in delivery, please indicate neonatal outcome: Birth date:_____/_____/_____

☐ Healthy newborn ☐ Ill newborn, describe:_____ ☐ Newborn died: Date____/___/_____ ☐ Unknown

65. Additional notes regarding discharge:

XIII. Additional Comments

66. Additional Comments:

Form Approved

OMB No. 0920-1011
Exp. Date 03/31/2017

Verbal Consent / Assent Script

Hi, my name is _____. I'm working with the health department and this shelter to find out what has been making some children here sick with fever and cough. We'd like to ask you some questions about the symptoms you've had in the last week. We will swab your nose and throat to test for any germs that might be making you sick. You don't have to answer our questions or allow us to swab your nose and throat; you can decide if you want to talk to us and let us swab you. We can answer any questions that you have about the study and procedures. Do you have any questions?

May I ask you some questions now? □ Yes □ No

(Complete questionnaire)

May I swab your nose and throat now? □ Yes □ No

Place sticker with Alien number here,

DO **NOT** PUT CHILD's NAME ON THIS FORM

Verbal consent obtained by: _____Date: _____

Form Approved

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Consentimiento Verbal

El párrafo a continuación se leerá al entrevistado y las respuestas serán registradas por el entrevistador:

Hola, me llamo_____, estoy trabajando con el departamento de salud y este refugio para tratar de entender por qué algunos niños de éste refugio se están enfermando con fiebre y con tos. Nos gustaría hacerte algunas preguntas sobre los síntomas que has tenido la semana pasada. Vamos a pasarte un hisopo por la nariz y por la garganta para detectar algunos gérmenes que podrían estar enfermándote. No tienes que responder a nuestras preguntas o dejarte pasar el hisopo si no quieres; o si quieres podemos hacerte las preguntas y pasar un hisopo por la nariz y garganta. Podemos responder a cualquier pregunta que tengas sobre este estudio y los procedimientos. Tienes alguna pregunta?

¿Puedo hacerte algunas preguntas ahora? □ Sí □ No
(Cuestionario completo)
¿Puedo pasar el hisopo por la nariz y garganta ahora? □ Sí □ No

Place sticker with Alien number here, DO **NOT** PUT CHILD's NAME ON THIS FORM

El consentimiento verbal fue obtenido por: _____Fecha: _____