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

CONSENT/PARENTAL PERMISSION FORM

Suspected chikungunya or dengue virus infections among community service volunteers in the Dominican Republic, 2014

The US Centers for Disease Control and Prevention is working with Amigos de las Américas, Inc., and the Texas Department of Health to investigate possible chikungunya virus infections among volunteers and staff. Chikungunya is a disease characterized by fever and joint pains. The virus that causes this disease is transmitted by the same mosquito that transmits another virus called dengue virus. Dengue virus has been present in the Dominican Republic for many years. Chikungunya virus was only recently introduced into the Dominican Republic.

We are trying to find out how many volunteers and staff deployed to the Dominican Republic this summer got chikungunya or dengue. We will try to identify people who got infected but who may not have known they were infected. We also want to know, of those who got ill with a fever, how many were infected by the chikungunya or dengue viruses. Finally, we are trying to get information about the daily practices of people who got infected. With this information, we will try to figure out factors that may have contributed to chikungunya and dengue virus infections and what are effective avoidance measures.

We would like to ask that you/your child fill out a questionnaire that we have developed to try to answer the questions in the above paragraph. We expect that it will take about 20 minutes to complete. We would also like to take approximately 1 ½ tablespoons of blood, which we will use to test whether you have/your child has been recently infected with the viruses that cause chikungunya and dengue. As is standard procedure in these types of investigations, if any of the blood sample is left over, we would like to store it for future chikungunya and dengue testing. We will NOT perform any genetic or HIV testing on it or test for other diseases.

We will give you the results of your/your child's test, but they will not be available in time to be useful in making any decisions about your health care. If the test shows that you/your child had a recent chikungunya or dengue virus infection, we will also inform the health department in the state where you live.

In addition to the questionnaire, we are aware that Amigos de las Américas, Inc., collects health information on a weekly health log for each participant as well as clinical information when a participant

becomes ill. This information may be helpful to us in determining when people became ill as well as the extent of their illness. Therefore we would like to obtain this information for volunteers whose illnesses are compatible with chikungunya or dengue.

All the information you/your child give(s) us will be kept private to the extent possible, and only the investigators working on the investigation will be able to see it. There is a small risk though that personnel not involved with the investigation could see your information. Reports of the investigation will be summaries, and no information will be shared with others, including Amigos de las Américas, Inc., that can identify you or your child personally. Answering the questions is completely voluntary, and you/your child can stop answering questions any time. You/your child can also decide not to answer any particular question. The same applies to the blood specimens.

Do you have any questions? If not, please read the statements below and if you agree, sign and date the form where indicated. If you do not agree to any of the following statements, please draw a line through the statement you do not agree with and initial next to the line.

- I agree to answer questions
- I agree to have my or my child's blood drawn
- I agree to allow my or my child's blood to be stored for future chikungunya and dengue testing
- I agree to allow Amigos de las Américas, Inc., to furnish my or my child's weekly health log and related health information to investigators
- I agree to be contacted by investigators or Amigos de las Américas, Inc., in the future in case any clarifications to data already collected are needed, and to receive chikungunya and dengue test results and information

Participant Name: _____ Date: _____

Parent/Guardian Name:_____ Signature:_____

ASSENT FOR MINORS <18 YEARS OF AGE

Suspected chikungunya or dengue virus infections among community service volunteers in the Dominican Republic, 2014

We are working with the U.S. Centers for Disease Control and Prevention to try to determine if there were volunteers or staff that experienced an illness called 'chikungunya' in the Dominican Republic. This disease causes fever and body pain, and is transmitted by the same mosquitoes that transmit dengue virus. Chikungunya virus was only recently introduced into the Dominican Republic and illnesses from this virus have been reported. We are trying to find out how many people may have been infected among the volunteers and staff deployed to the Dominican Republic this summer. We will try to identify people who got infected but who may not have known that they were infected and, of those who got ill with a fever, how many had symptoms due to chikungunya or dengue. In addition, we are trying to get information about the daily practices of people who got sick to try to figure out factors that may have contributed to chikungunya and dengue virus infections and what might be effective avoidance measures.

To do that, we would like to ask you some questions about things that you were doing during your time in the Dominican Republic . We would also like to take approximately 1 ½ tablespoons of blood, which we will use to test for evidence of having been recently infected with the viruses that cause chikungunya and dengue. This would mean that we would put a small needle in your arm and take some of your blood. It might pinch a little at first, but should not be too painful. This is to test for chikungunya and dengue. Your parent/guardian has given their permission for you to answer these questions and give some blood. You may now choose whether or not to proceed with participation in this investigation.

- I agree to answer the questionnaire
- I agree to have my blood drawn

Name:_____ Date:_____

Signature:_____

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

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Suspected chikungunya or dengue virus infections among community service volunteers in the Dominican Republic, 2014

What is your name?_____(Last, First,MI)

This page will be removed after a unique identifier is applied and accuracy is checked.

None of your answers to any of the questions in this questionnaire will be shared with staff from your service organization.

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

****

Demographic Information and Previous Travel History

****

0. What is your age? _____

1. Sex: □ Male □ Female

2. What countries outside of the continental United States have you ever visited before this trip to the Dominican Republic (please also list such places as Puerto Rico, the US Virgin Islands, and Guam)?
_____
_____
_____

3. Have you received the yellow fever vaccine in the past? □ Yes □ No □ Don't know

4. Have you received the Japanese encephalitis vaccine in the past? □ Yes □ No □ Don't know

****

Trip Illness History

****

5. Have you experienced a **fever** since you arrived in the Dominican Republic?
□Yes □ No

If yes, please specify as accurately as possible the following information about each of your illnesses with fever on the next page. **If no, skip to Question 6.**

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

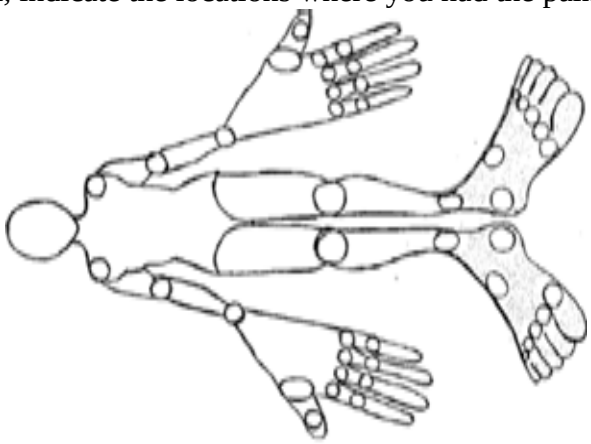
Illness with fever #1

5.1a. What date did you become ill (approximately)? : Month: _____ Day: _____

5.1b. Please check all that apply

□ Chills □ Headache □ Runny nose □ Sore throat
□ Red eyes □ Eye pain/pain behind eyes □ Cough
□ Nausea/Vomiting □ Diarrhea □ Abdominal pain/discomfort
□ Muscle pain □ Calf pain □ Joint pain □ Red or swollen joints
□ Skin rash
□ Minor bleeding (e.g., petechiae (small red/purple sometimes raised spots on skin), gum bleed, nosebleed, excessive or unusual bruising)
□ Major bleeding (e.g., vomiting blood, coughing up blood, blood in stool, heavy menses)

5.1c. If you had joint pain, indicate the locations where you had the pain



5.1d. Approximately how long did this illness last? _____ days

5.1e. Did you activate your emergency CALM plan because of this illness?
□ Yes □ No

5.1f. Did you go to the doctor because of this illness? □ Yes □ No

5.1g. What was the diagnosis?
□Chikungunya □ Dengue □ Viral syndrome □ I don't know
□ Other: If other, please specify _____

5.1h. Were you hospitalized for this illness? □ Yes □ No

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

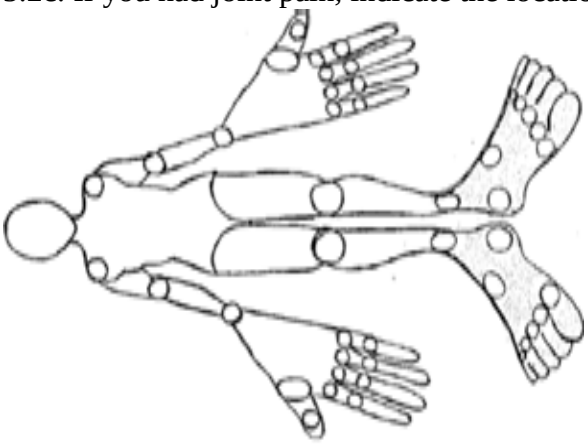
Illness with fever #2

5.2a. What date did you become ill (approximately)? : Month: _____ Day: _____

5.2b. Please check all that apply

□ Chills □ Headache □ Runny nose □ Sore throat
□ Red eyes □ Eye pain/pain behind eyes □ Cough
□ Nausea/Vomiting □ Diarrhea □ Abdominal pain/discomfort
□ Muscle pain □ Calf pain □ Joint pain □ Red or swollen joints
□ Skin rash
□ Minor bleeding (e.g., petechiae (small red/purple sometimes raised spots on skin), gum bleed, nosebleed, excessive or unusual bruising)
□ Major bleeding (e.g., vomiting blood, coughing up blood, blood in stool, heavy menses)

5.2c. If you had joint pain, indicate the locations where you had the pain



5.2d. Approximately how long did this illness last? _____ days

5.2e. Did you activate your emergency CALM plan because of this illness? □ Yes □ No

5.2f. Did you go to the doctor because of this illness? □ Yes □ No

5.2g. What was the diagnosis?
□Chikungunya □ Dengue □ Viral syndrome □ I don't know
□ Other: If other, please specify _____

5.2h. Were you hospitalized for this illness? □ Yes □ No

*****If more than two illness with fever, please request additional answer sheets*****

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

****

Experiences at Study Site

****

6. Did the house that you were staying at have:
   - 6.1. Screens on the window? □ Yes □ No
   - 6.2. Screens on the doors? □ Yes □ No
   - 6.3. Air-conditioning? □ Yes □ No

7. Do you remember being bitten by mosquitoes during your 2014 trip to the Dominican Republic?
   □ Yes □ No (Skip to question 8)

   7.1 If yes, please indicate the time of day when you were bitten by mosquitoes **most often** (please choose a single answer)
   - a) morning
   - b) afternoon
   - c) early evening
   - d) late evening

8. How frequently did you apply/use insect repellent during your trip to the Dominican Republic?
   - a) Once daily
   - b) Multiple times a day (Please specify number of times per day _____)
   - c) Not every day, but when I noticed mosquitoes were around.
   - d) Never (Skip to question 9)
   - e) Other (Please specify_____)

   8.1 Did the repellent have any of the following active ingredients (Please circle all that apply)?
   - a) DEET (specify percent: _____)
   - b) Picaridin
   - c) Oil of Lemon Eucalyptus (or PMD)
   - d) IR3535
   - e) Other (Please specify _____)
   - f) I do not know what the active ingredient was.

9. Did you treat your clothing with insecticide (permethrin) before you traveled to the Dominican Republic?
   □ Yes □ No (Skip to Question 10)

   9.1 If yes, did you retreat your clothing at any time during your trip to the Dominican Republic?
   □ Yes □ No

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

10. Which of the following did you also do during your travel to the Dominican Republic to protect yourself from being bitten by mosquitoes? (Please circle all that apply):

a) Wore long sleeves shirts
b) Wore long pants
c) Wore a hat
d) Wore close-toed shoes (such as tennis shoes)
e) Bed nets
f) Mosquito coils
g) Used insecticide aerosols (to spray in room and not on skin)
h) None of these
i) Other (Please specify _____)

11. Did you travel to other areas (outside of your service location) of the Dominican Republic?

□Yes □ No

11.1 If yes, please indicate places and days spent there:
Location 1: _____ #days _____
Location 2: _____ #days _____
Location 3: _____ #days _____

****

Pre-Travel Health Preparation for the June/July 2014 Trip to the Dominican Republic

****

12. Did you seek pre-travel advice from a healthcare provider (doctor, nurse, nurse practitioner, or physician assistant) before your summer 2014 trip to the Dominican Republic?

□ Yes □ No (skip to question 18)

12.1. If yes, what type of clinic did you go to prior to your trip to the Dominican Republic?

a) Your primary care provider or personal medical provider (e.g. pediatrician, family practitioner, nurse practitioner, etc.)
b) A local public health department clinic
c) A travel medicine specialty clinic
d) Other (please specify: _____)

13. Did you receive any specific information on health risks or diseases present in the Dominican Republic during this appointment? □ Yes □ No

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

14. Did you receive any specific information about how to avoid mosquito bites during this appointment?

□ Yes □ No (skip to question 15)

14.1. If yes, what recommendations did the clinician give you to prevent mosquito bites? (Circle all that apply)

a) Wear long sleeves
b) Wear long pants
c) Wear a hat
d) Wear close-toed shoes (such as tennis shoes)
e) Applied insect repellent (bug spray or lotion) (Please specify brand name, color of bottle- for example Deep Woods OFF has green bottle)

_____

f) Bed nets
g) Mosquito coils
h) Insecticide aerosols (to spray in room and not on skin)
i) Insecticide treated clothing
j) None of these
k) Other (Please specify _____)

14.2 Did these recommendations influence you to use the following prevention measures?

a)	Applied insect repellent	□ Yes	□ No
b)	Wear protective clothing	□ Yes	□ No
c)	Bed nets	□ Yes	□ No
d)	Mosquito coils	□ Yes	□ No
e)	Insecticide aerosols (to spray in room and not on skin)	□ Yes	□ No
f)	Insecticide treated clothing	□ Yes	□ No

15. Did you receive any specific information about dengue during this appointment?

□ Yes □ No

16. Did you receive any specific information about chikungunya during this appointment?

□ Yes □ No

17. From what additional source(s) did you seek health information about the Dominican Republic before your travel?

a) Online/website(s) (please specify:_____)
b) Primary care physician
c) Friend(s)/Family
d) Travel/Trip coordinator
e) Television
f) Periodicals/Newspapers (please specify: _____)
g) Magazines (please specify: _____)
h) Other(please specify: _____)
i) None

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

****

Pre-departure training (Program Orientation)

****

18. Did you receive any specific information on health risks or diseases in the Dominican Republic during your pre-departure training with your service organization? □Yes □ No

19. Did you receive any specific information about how to avoid mosquito bites during this pre-departure training? □Yes □ No (skip to question 20)

19.1. If yes, did the information in this training influence you to use the following prevention measures?

a) Applied insect repellent	□ Yes	□ No
b) Wear protective clothing	□ Yes	□ No
c) Bed nets	□ Yes	□ No
d) Mosquito coils	□ Yes	□ No
e) Insecticide aerosols (to spray in room and not on skin)	□ Yes	□ No
f) Insecticide treated clothing	□ Yes	□ No

20. Did you receive any specific information about dengue during this pre-departure training?
□Yes □ No

21. Did you receive any specific information about chikungunya during this pre-departure training?
□Yes □ No

****

In-country training/briefing (Program Orientation)

****

22. Did you receive any specific information on health risks or diseases in the Dominican Republic during this in-country training? □Yes □ No

23. Did you receive any specific information about how to avoid mosquito bites during this in-country training?
□Yes □ No (skip to question 24)

23.1. If yes, did the information in this training influence you to use the following prevention measures?

a) Applied insect repellent	□ Yes	□ No
b) Wear protective clothing	□ Yes	□ No
c) Bed nets	□ Yes	□ No
d) Mosquito coils	□ Yes	□ No
e) Insecticide aerosols (to spray in room and not on skin)	□ Yes	□ No
f) Insecticide treated clothing	□ Yes	□ No

24. Did you receive any specific information about dengue during in-country training? □Yes □ No

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

25. Did you receive any specific information about chikungunya during in-country training?
□Yes □ No

****

Knowledge of health and safety before travel, pre-travel health visit, and program training (both pre-departure and in-country)

****

26. Before signing up for this trip to the Dominican Republic and your training with your service organization, how much did you know about dengue?
    a) A lot
    b) Some
    c) A little
    d) Nothing, never heard of it before going to the Dominican Republic (Skip to question #31)

27. Before this trip to the Dominican Republic and your training, did you know that dengue was transmitted by mosquitoes? □Yes □ No

28. Before this trip to the Dominican Republic and your training, did you think that you could be exposed to dengue while in the Dominican Republic? □Yes □ No

29. Before this trip to the Dominican Republic and your training, did you know that there was no vaccine for dengue? □Yes □ No

30. Before this trip to the Dominican Republic and your training, did you know that there was no treatment specifically for dengue? □Yes □ No

31. Before signing up for this trip to the Dominican Republic and your training with your service organization, how much did you know about chikungunya?

    a) A lot
    b) Some
    c) A little
    d) Nothing, never heard of it before going to the Dominican Republic (Skip to question #36)

32. Before this trip to the Dominican Republic and your training, did you know that chikungunya was transmitted by mosquitoes? □Yes □ No

33. Before this trip to the Dominican Republic and your training, did you think that you could be exposed to chikungunya while in the Dominican Republic? □Yes □ No

34. Before this trip to the Dominican Republic and your training, did you know that there was no vaccine for chikungunya? □Yes □ No

35. Before this trip to the Dominican Republic, did you know that there was no treatment specifically for chikungunya? □Yes □ No

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

****

Comments

****

36. Please list any other comments you wish to share:

_____
_____
_____
_____

Thank you for completing this questionnaire and participating in the study. If you develop a fever within 2 weeks of returning home, please seek medical care with a health care provider immediately and inform your service organization of this illness.

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Participant Identification Code _____.

Ebola and Infection Control

Knowledge, Attitudes, and Practices (KAP)

To be administered in person

Script: "Hello my name is [NAME]. I am working with the [LOCAL AUTHORITY] and the US Centers for Disease Control and Prevention. We would like you to take part in a brief survey. The purpose of this survey is to gather information that will help us develop a program and training that help us respond to Ebola. We will keep the information you give us private and confidential. We will not take down your name, so your responses cannot be linked to you. Only members of the survey team will be allowed to look at the records. This survey is voluntary.

Demographics *Who I am….*

1. Facility Name:

2. Facility Type

2. Age:

4. Sex:

- ☐ Male
- ☐ Female

5. Job Title:

6. How many years of experience do you have as a Health Care Worker?

- ☐ Less than 1 year
- ☐ 2 to 5 years
- ☐ 6 to 10 years
- ☐ More than 10 years

7. What is the highest level of professional education you have achieved?

- ☐ Enrolled Nurse
- ☐ Registered Nurse
- ☐ Registered Nurse with Bachelor's Degree (BSN)
- ☐ Registered Nurse with Master's Degree
- ☐ Physician
- ☐ Other _____

8. What is the number of hours you spend each week on the following activities?

Providing Direct Patient Care _____ hours

Supervising Health Care Workers _____ hours

Performing administrative tasks _____ hours

Training Health Care Workers _____ hours

KNOWLEDGE *What I know ....*

Please select your level of agreement or disagreement with each statement below. **Please check (ü) one for each statement.**	**Agree**	**Disagree**
General Infection Control and Occupational Health Risks		
9. A common way infections are spread in hospitals is from unclean hands of health care workers.		
10. Crowded conditions in hospitals increase the chance of spreading infections from one person to another.		
11. When I have an inquiry about infection control, I know whom to ask at this hospital for help.		
Hand Hygiene Concerns		
12. Hand washing before and after every patient contact will reduce the spread of infection among hospitalized patients.		
13. Waterless hand gel is an acceptable substitute for hand washing with soap and water, as long as hands are not visibly soiled.		
14. Health care workers should always wear gloves when conducting patient care activities.		
Ebola Knowledge – Self protection		
15. I can get Ebola from touching a healthy (asymptomatic) person's skin		
16. I can get Ebola from touching an Ebola patient's skin		
17. I can get Ebola from cleaning up vomit, pee, or poo from an Ebola patient		
18. I can get Ebola from touching clothes or bedding of an Ebola patient		
19. I can get Ebola from touching a dead body		
20. I can protect myself from Ebola by washing my hands with soap and water		
21. I can protect myself from Ebola by cleaning my hands with alcohol-based hand sanitizer, as long as my hands are not visibly soiled		
22. I can protect myself from Ebola by wearing gloves		
23. I can protect myself from Ebola by wearing other PPE (gown, face mask/shield, shoe covers)		
24. I can protect myself from Ebola by removing soiled gloves carefully (without touching my skin)		
Ebola Knowledge – Infection control		
25. Ebola can spread in hospitals from unclean hands of healthcare workers		
26. Ebola can spread in hospitals when healthcare workers reuse gloves with more than one patient		
27. Ebola can spread in hospitals when healthcare workers reuse other PPE (gown, face mask/shield, shoe covers) with more than one patient		
28. Crowded conditions in hospitals can increase the spread of Ebola among patients		
29. Any patient with a fever who has also had contact with an Ebola patient (whether alive or dead) should be treated as if they have Ebola		
30. Healthcare workers should contact the county health director about every suspected Ebola patient		
31. The same pair of gloves may be used on several patients without increasing the risk of disease transmission, as long as the gloves are not visibly soiled.		

ATTITUDES *How I feel …*		
Please select your level of agreement or disagreement with each statement below. **Please check (ü) one for each statement.**	**Agree**	**Disagree**
General Infection Control and Occupational Health Risks		
32. I feel it is my personal responsibility to prevent infections among the patients for whom I care.		
33. Preventing the spread of infections in this hospital is important to our hospital administrators.		
34. My hospital has adequate resources to prevent the spread of infections among patients.		
35. During my educational training, I received adequate instruction on infection control and the prevention of infections in hospitals.		
36. When I have an inquiry about infection control, I feel confident there is someone at this hospital I can go to for correct information.		
Hand Hygiene Concerns		
37. One important reason I wash my hands is to protect **myself** from infections.		
38. One important reason I wash my hands is to protect **my patients** from infections.		
39. Washing my hands before and after touching patients will make my hands become dry and uncomfortable.		
40. There is not enough time to wash my hands between every patient.		
41. I would wash my hands before and after every direct patient contact if soap and water were readily available.		
42. I would use hand sanitizer gel before and after every direct patient contact if it was readily available		
43. Washing my hands before and after direct patient contact is a necessary part of my job.		
44. My supervisors at this facility expect me to wash my hands before and after direct patient contact.		
45. My coworkers at this hospital wash their hands before and after patient contact.		
46. I intend to wash my hands before and after every patient contact, regardless of my clinical assignment.		
Ebola-specific Concerns		
47. I feel it is my personal responsibility to care for Ebola patients		
48. I am able to adequately care for Ebola patients because I am confident I can protect myself from getting Ebola.		
49. Infection control practices for Ebola are nearly the same as infection control practices for other diseases I have worked with.		
50. During this epidemic, I am expected to treat Ebola patients whether or not I feel prepared to treat them or to protect myself from Ebola.		
Ebola Attitudes - Hospital		
51. My hospital has enough gloves to change between every patient		
52. My hospital has enough other PPE (gown, face mask/shield, shoe covers) change between every patient		
53. My hospital has enough staff to treat Ebola patients		
54. My hospital has enough soap and water available for handwashing		
55. My hospital has enough alcohol-based hand sanitizer		
Ebola Attitudes - Capability		
56. I received adequate training in Ebola prevention and treatment		

Please select your level of agreement or disagreement with each statement below. **Please check (ü) one for each statement.**	**Agree**	**Disagree**
57. I have someone to ask for help if I need it		
58. I can wash my hands when I need to		
59. I feel confident that I can protect myself from Ebola		
Ebola Attitudes – Patient care		
60. It is my responsibility to treat Ebola patients		
61. It is my choice to treat Ebola patients		
62. I feel pressure from my supervisors to treat Ebola patients		
63. I feel pressure from my co-workers to treat Ebola patients		
64. It is expected that I treat Ebola patients, whether or not I feel prepared		
65. I feel scared treating Ebola patients		
66. I feel comfortable treating Ebola patients		

PRACTICES *What I do ...*

Please select the frequency you perform each practice listed below. **Please check (ü) one for each statement.**	**Always**	**Most of the time**	**Some-times**	**Never**
General Infection Control and Occupational Health Risks				
67. I teach my patients ways they can prevent the spread of infections.				
68. When I am ill with a respiratory infection, I stay home from work.				
69. When I have an inquiry about infection control, I ask someone on the infection control team for help.				
Hand Hygiene Concerns				
70. I wash my hands after removing gloves.				
71. I wash my hands before touching a patient.				
72. I wash my hands after touching a patient.				
Ebola practices				
70. I wear PPE (personal protective equipment) when caring for Ebola patients				
71. I change my PPE after seeing each Ebola patient				
72. I wash my hands after touching each Ebola patient.				
73. I complete a case report form for each Ebola patient.				
74. I dispose of soiled items from Ebola patients (PPE, bedding, clothing, etc.) in a special Ebola-specific waste container.				

TRAINING
What I prefer....

Please answer the following questions about Ebola training:

75. Have you ever received training in Ebola patient care?

- ☐ Yes
- ☐ No

76. If you answered 'Yes' to question 75, do you feel you were adequately prepared by your training?

- ☐ Yes
- ☐ No

77. Have you ever received training in Ebola infection control practices (how to prevent transmission among patients)?

- ☐ Yes
- ☐ No

78. If you answered 'Yes' to question 77, do you feel you were adequately prepared by your training?

- ☐ Yes
- ☐ No

Thank you very much for completing this questionnaire.

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Structured Interview of County Health Director

1. Date of interview (*dd*/*mm*/*yyyy*) - ___/___/___
2. Name of interviewer _____
3. County _____
4. Name of County Health Director_____
5. Contact information of County Health Director_____
6. Has there been a WHO gap analysis performed? Y N
   a. *If yes, then* Is a copy of the analysis available? Y N
7. Do you have a county Ebola response plan? Y N
8. What percentage of their work hours are county health officials/workers currently spending on Ebola? ___

Healthcare Facilities

Hospital Name	ETU?	Location (Village name)	Operating before Ebola outbreak?	Operating now?	# of beds
9.	9a. Y N	9b.	9c. Y N	9d. Y N	9e.
10.	10a. Y N	10b.	10c. Y N	10d. Y N	10e.
11.	11a. Y N	11b.	11c. Y N	11d. Y N	11e.
12.	12a. Y N	12b.	12c. Y N	12d. Y N	12e.
13.	13a. Y N	13b.	13c. Y N	13d. Y N	13e.

Health Center Name	Location (Village name)	Operating before Ebola outbreak?	Operating now?
14.	14a.	14b. Y N	14c. Y N
15.	15a.	15b. Y N	15c. Y N
16.	16a.	16b. Y N	16c. Y N
17.	17a.	17b. Y N	17c. Y N
18.	18a.	18b. Y N	18c. Y N
19.	19a.	19b. Y N	19c. Y N
20.	20a.	20b. Y N	20c. Y N
21.	21a.	21b. Y N	21c. Y N
22.	22a.	22b. Y N	22c. Y N
23.	23a.	23b. Y N	23c. Y N

   a. *Use blank sheet to list additional health centers*

24. What are the major reasons that some hospitals/health centers are not open? *(circle all that apply)*
    No healthcare workers Fear of Ebola Lack of medical supplies Civil unrest
    Other _____
25. Are there plans to open an Ebola treatment unit (ETU)?
    a. *If yes, then* Where _____
    b. When _____
    c. # of beds ___
    d. Have health workers been identified? Y N
26. Are there plans to open a holding center?
    a. *If yes, then* Where_____
    b. When _____
    c. Will this center have isolation rooms or isolation wards? Y N
    d. Will suspect and confirmed cases be separated? Y N
    e. Will there be separate entrances for patients and staff? Y N
    f. Will the toilets be individual or shared? Y N
    g. # of beds ___
    h. Have health workers been identified? Y N

i.

27. Are healthcare workers being paid? Y N
    a. *If no, then* When was the last time they were paid? _____
28. Have healthcare workers received any training in Ebola treatment? Y N
    a. *If yes,* When? _____
    b. Performed by_____
29. What services are currently provided by the healthcare system in this county?
    a. EPI (Expanded Program on Immunization)
    b. Malaria testing and treatment
    c. HIV screening and treatment
    d. Antenatal care
    e. Obstetric care
    f. Surgery

Infection Control

30. Have healthcare workers received training in infection control (including PPE)? Y N
    a. *If yes, then* When? _____
    b. Performed by_____
31. Do you store and distribute PPE? Y N
32. Where do you get your PPE from? _____
33. Do you store and distribute body bags? Y N
34. Do you store and distribute disinfectant, such as chlorine and alcohol? Y N
35. What items or trainings are needed for infection control?
    a. _____
    b. _____
    c. _____
    d. _____

Ambulances

36. Do you have a plan to safely transport suspected Ebola patients?
    a. *If yes, then* What is the plan? _____
    _____
37. Has ambulance staff been trained on safe transport of suspected Ebola patients? Y N
38. How many ambulances are available in this county? ___
39. If there are no ambulances, then how are patients transported to a healthcare facility? _____
    _____
40. What is the protocol if a patient is unable to be transported?
    _____
    _____
41. Is fuel available consistently for the ambulances? Y N
42. Are ambulances available 24 hours a day, 7 days week? Y N
43. Do you have adequate equipment for ambulance staff?
    a. PPE Y N
    b. Chlorine Sprayer Y N
    c. Boots Y N
    d. Disinfectant Y N
44. Does the ambulance team disinfect the home after removing the patient? Y N
45. What items or trainings are needed for ambulances?
    a. _____
    b. _____
    c. _____

Specimen Collection

46. Are samples collected from patients in this county? Y N
    a. Name of nearest lab facility ELWA3 LIBR Other_____
    b. How are samples shipped? _____
47. What is the turn-around time for Ebola specimens after collection? (i.e., from sample collection to result reporting) _____
48. Have lab technicians collecting specimens received training on infection control? Y N

a. *If yes,* When? _____
b. Performed by_____

49. Are lab technicians being paid? Y N
    a. *If no, then* When was the last time they were paid? _____
50. Are specimens being collected from dead bodies? Y N
    a. *If yes, then* What type of specimen is being collected? _____
51. What items or trainings are needed for laboratories?
    a. _____
    b. _____
    c. _____

Case Investigation

52. Please describe the protocol for case investigation
    _____
    _____
    _____

53. Is there an SOP in place for case investigation? Y N
54. How many members are on the case investigation team? _____
    a. Role #1_____
    b. Role #2_____
    c. Role #3_____
    d. Role #4_____
    e. Role #5_____
55. How do case investigation teams travel?_____
56. How many case investigation teams are in the county? __
57. Is there a call center for Ebola? (a person or group who answers questions about Ebola) Y N
58. Who staffs the call center? _____
59. Have the call center workers received training on Ebola? Y N
    a. *If yes,* When? _____ Performed by_____
60. Is there a standardized call log for the call centers? Y N
61. What information is provided by the call centers? _____
    _____
62. What information is collected by the call centers? _____
    _____
63. What information is provided to suspect Ebola patients?
    _____
    _____
64. How many case-investigation forms do you have in the county? ___
65. Do you have case ID# stickers? Y N
66. Are case identification forms pre-labeled? Y N
67. What items or trainings are needed for case identification?
    a. _____
    b. _____
    c. _____

Data Management

68. Describe data flow from county to central Ministry of Health database
    _____
    _____
    _____
    _____
    _____
69. Is the county copying case investigation forms before sending to the Ministry of Health? Y N
70. Is the county maintaining a line list of suspect cases? Y N
71. Are there regular meetings of county health officials for Ebola? Y N
    a. *If yes, then* How frequently? _____times per week / month (circle one)
72. Does the county have Epi Info? Y N
73. Have county staff been trained in Epi Info? Y N

74. Are county staff able to send Epi Info data to the Ministry of Health? Y N
75. What items or trainings are needed for data management?
    a. _____
    b. _____
    c. _____

Contact Tracing

76. How many contact tracing teams are working in the county? _____
77. How many individuals work on each contact tracing team? ___
    a. Role #1_____
    b. Role #2_____
    c. Role #3_____
78. Is there an SOP for contact tracing in place? Y N
79. What is the average time from completion of the contact tracing form to submission to the Ministry of Health database? ___
80. Are contacts classified by high or low risk? Y N
    a. *If yes, then* What is recommended for high risk contacts? *(circle all that apply)*
        i. Home isolation
        ii. Temp monitoring
        iii. Daily visit
        iv. Other _____
81. Is food being provided to contacts? Y N
82. What information is provided to contacts at the end of the 21 day tracing period?
    _____
83. Have contact tracers received training on Ebola? Y N
    a. *If yes,* When? _____
    b. Performed by_____
84. Are contact tracers being paid? Y N
    a. *If no,* When was the last time they were paid? _____
85. How do contact tracers travel? _____
86. What items or trainings are needed for contact tracing?
    a. _____
    b. _____
    c. _____

Burial Teams

87. Is there an SOP in place for safe burials of Ebola cases? Y N
88. Describe the SOP for safe burials _____
    _____
89. How many burial teams are currently operating in this county? ___
90. Do burial teams have PPE? Y N
91. Does the burial team disinfect the home after removing the body? Y N
92. What items or trainings are needed for burial teams?
    a. _____
    b. _____
    c. _____
    d. _____

Health Communication

93. How are messages regarding Ebola distributed in the community? *(circle all that apply)*
    a. Fliers
    b. Radio
    c. SMS
    d. Other _____
94. What groups are performing health education? _____
    _____
95. What items or trainings are needed for health communication?
    a. _____

b. _____
c. _____

Community Engagement Strategy

96. Have health officials met with community leaders to develop a communication and messaging plan? Y N

Home Hygiene Kits

97. Are home hygiene kits being distributed? Y N
98. Who is distributing them? _____
99. Where are they being distributed? *(circle all that apply)*
    a. Healthcare facilities
    b. Homes
    c. Other_____
100. How many kits have been distributed to date? ___
101. Were instructions included in the kits? Y N
102. What is included in the home hygiene kits?

_____
_____

103. What items or trainings are needed for home hygiene kits?
    a. _____
    b. _____
    c. _____

Psychosocial Support

104. Is psychosocial support provided as part of the Ebola response? Y N
105. What aspects of the response have a psychosocial member involved?
    a. Case management
    b. Contact tracing
    c. Delivering lab results
    d. Burial team
    e. Survivor reintegration
    f. Contacts who complete 21 day tracing
    g. Other _____
106. How many people are trained in psychosocial support/mental health in the county? ___

Miscellaneous

107. Are any communities currently under quarantine? Y N
    a. *If yes, then* How are those communities getting food, medical supplies, etc.?_____
    _____
108. Are there any other health issues in the county that you are concerned about, such as measles?
    a. _____
    b. _____
    c. _____

Health Center Name	Location (Village name)	Operating before Ebola outbreak?	Operating now?
		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N
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		Y N	Y N
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		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N
		Y N	Y N

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

Participant Identification Code _____. Survey Date_____

Ebola

Knowledge, Attitudes, and Practices (KAP)

To be administered in person

Script: "Hello my name is [NAME]. I am working with the [LOCAL AUTHORITY] and the US Centers for Disease Control and Prevention. We would like you to take part in a brief survey. The purpose of this survey is to gather information that will help us give you better information about Ebola. We will keep the information you give us private and confidential. We will not take down your name, so your responses cannot be linked to you. Only members of the survey team will be allowed to look at the records. This survey is voluntary.

Demographics ***Who I am....***
1. County
2. District or Community
2. Age:
4. Sex: ☐ Male ☐ Female
5. Job Title:
7. What is the highest level of education you have achieved? ☐ Primary ☐ Middle ☐ Secondary ☐ Vocational/Technical ☐ Tertiary/University ☐ Professional/Advanced degree ☐ Other _____

Knowledge, Attitudes, and Practices		
Please select your level of agreement or disagreement with each statement below. **Please circle one for each statement.**	**Agree**	**Disagree**
Ebola Knowledge		
1) I can get Ebola from a healthy (asymptomatic) person	**A**	**D**
2) I can get Ebola from kissing a symptomatic person	**A**	**D**
3) I can get Ebola from sharing a spoon / fork with a symptomatic person	**A**	**D**
4) I can get Ebola from sleeping in the same bed as a symptomatic person	**A**	**D**
5) I can get Ebola from cleaning up vomit from a symptomatic person	**A**	**D**
6) I can get Ebola from having sex with a symptomatic person, even if I wear a condom	**A**	**D**
7) I can get Ebola from cleaning up pee or poop from a symptomatic person	**A**	**D**

8) I can get Ebola from touching a dead person	**A**	**D**
9) I can get Ebola from washing a dead person	**A**	**D**
10) I can get Ebola from cleaning the sheets from a funeral of an Ebola patient	**A**	**D**
11) I can get Ebola from eating bush meat	**A**	**D**
12) I can get Ebola from attending a burial of an Ebola patient	**A**	**D**
Please select your level of agreement or disagreement with each statement below. **Please circle one for each statement.**	**Agree**	**Disagree**
13) A baby can get Ebola from breastfeeding from a symptomatic mother	**A**	**D**
14) Fever is a symptom of Ebola	**A**	**D**
15) Handwashing can prevent transmission of Ebola	**A**	**D**
Ebola Attitudes		
16) Ebola is a real disease	**A**	**D**
17) Ebola is a serious disease	**A**	**D**
18) Anyone can get Ebola (even healthy people)	**A**	**D**
19) I am worried about getting Ebola	**A**	**D**
20) I am at risk for getting Ebola	**A**	**D**
21) I can get Ebola if someone puts a curse / spell on me	**A**	**D**
22) I am afraid of people with Ebola	**A**	**D**
23) I am afraid of people who live with Ebola patients	**A**	**D**
24) I am afraid of treatment centers	**A**	**D**
25) I am afraid of people who have been cured of Ebola	**A**	**D**
26) I would know if I had Ebola symptoms	**A**	**D**
27) I know how to protect myself from getting Ebola	**A**	**D**
Anticipated Practices		
28) If I got Ebola symptoms, I would seek treatment	**A**	**D**
29) If I got Ebola symptoms, I know where to go for treatment	**A**	**D**
30) If I got Ebola symptoms, I would be afraid of going to a treatment center	**A**	**D**
31) If I got Ebola symptoms, I would go to a traditional healer	**A**	**D**
32) If I got Ebola symptoms, I would hide away in my house	**A**	**D**
33) If a friend or family member gets Ebola, I would take them to a treatment center	**A**	**D**
34) If a friend or family member gets Ebola, I would take them to a traditional healer	**A**	**D**
35) If a friend or family member gets Ebola, I would keep them in my house	**A**	**D**
Ebola Treatment Center Fears		
36) If I go to a treatment center, I will die	**A**	**D**
37) If I go to a treatment center, I will not be allowed to see my family	**A**	**D**
38) White people brought Ebola here	**A**	**D**

)

Form Approved
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Exp. Date 03/31/17

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:

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

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

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

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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Alien Number _____

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

d. Vasopressor medications (e.g. dopamine, epinephrine) Date started: / /	¨ Yes, date started: / /	Date stopped / /	¨ No ¨ Unknown
e. Dialysis (Acute) Date started: / /	¨ Yes, date started: / /	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:

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Verbal Assent for Pneumococcal Carriage Study

The following will be read to the potential study participant and responses will be recorded by the interviewer:

Hi, my name is _____. I'm working with the U.S. Centers for Disease Control and Prevention (CDC), the Office of Refugee Relocation, and this shelter to try to understand why some children in this shelter were sent to the hospital or emergency room with fever and cough. We'd like to put a swab in your nose to test for some germs. This test won't cause you any harm, but may be uncomfortable and might cause light bleeding. You may not get any direct benefit by doing this test, but by taking part you will help us to learn how to prevent more kids in the shelter from getting sick. You don't have to allow us to swab your nose; you can decide if you want to let us swab your nose. We can answer any questions that you have about the work we are doing and procedures.

May I swab your nose now? □ Yes □ No

Alien Number:

Place sticker with Alien number here,

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

Verbal consent obtained by: _____ Date: _____

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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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ASSESSMENT OF INFECTION CONTROL POLICIES AND PRACTICES.

Site/Shelter Name

_____

Medical Facility Point of Contact_____

Phone __ __ __ - __ __ __ - __ __ __ __ Email or Other Contact_____

Shelter POC_____

Department of Health POC_____

Section 1. Administrative Policies ,Shelter Practices and Education

	Practice performed (Yes, No)	If answer is No, document plan for remediation
Facility policies(Ask HCW manager/staff)		
a) Written infection prevention policies and procedures are available, current, and based on evidence-based guidelines (e.g., CDC/ HICPAC), regulations, or standards. *Note: Policies and procedures should be appropriate for the services provided by the facility and should extend beyond OSHA blood borne pathogen training*		
b) Infection prevention policies and procedures are re-assessed at least annually or according to state or federal requirements		
c) At least one individual trained in infection is employed by or regularly available to the facility		
d) Shelter has adequate supplies necessary for adherence to standard precautions readily available e.g. hand hygiene products, protective equipment. *Note: This includes hand hygiene products, personal protective equipment, and injection equipment.*		

General Infection Prevention Education and Training (Ask HCW manager/staff)		
a) Shelter staff and Health care workers(HCW) have received job-specific training on infection prevention policies and procedures e.g. proper selection and use of PPE *Note: This includes those employed by outside agencies and available by contract or on a volunteer basis to the facility.*		
b) Competency and compliance with job-specific infection prevention policies and procedures are documented both upon hire and through annual evaluations/assessments		
Occupational Health (Ask HCW manager/staff)		
a) HCP are trained on the OSHA blood borne pathogen standard upon hire and at least annually		
b) The facility maintains a log of needle sticks, sharps injuries, and other employee exposure events		
c) Following an exposure event, post-exposure evaluation and follow-up, including prophylaxis as appropriate, are available at no cost to employee and are supervised by a licensed healthcare professional		
d) Hepatitis B vaccination is available at no cost to all employees who are at risk of occupational exposure		
e) Post-vaccination screening for protective levels of hepatitis B surface antibody is conducted after third vaccine dose is administered		
f) All shelter staff and volunteers are offered annual influenza vaccination at no cost		
g) All shelter staff who have potential for exposure to tuberculosis (TB) are screened for TB upon hire and annually (if negative)		
h) Shelter staff are assessed for current immunization status upon admittance to the shelter and encouraged to receive vaccinations (MMR,DPT, Varicella, HepB)		
i) Shelter has a respiratory protection program that details required worksite-specific procedures and elements for required respirator use		
j) Respiratory fit testing is provided at least annually to appropriate HCP		

k) Facility has written protocols for managing/preventing job-related and community-acquired infections or important exposures in HCP, including notification of appropriate Infection Prevention and Occupational Health personnel when applicable		
l) Shelter staffs are excluded from work when ill with certain illnesses e.g. ILI till resolution of symptoms		
m) Shelter has protocols or guidance for prevention and response of conditions of outbreak potential among UC and shelter staff.		
Surveillance and Disease reporting (Ask HCW manager/staff)		
a) An updated list of diseases reportable to the public health authority is readily available to all personnel		
b) The facility can demonstrate compliance with mandatory reporting requirements for notifiable diseases, healthcare associated infections, and for potential outbreaks.		
c) Is there an assessment plan to triage and screen UC and staff upon initial admission/registration? If Yes, describe step by step processes Is there documentation of triage process? (need to ask this of two other people who work at intake)		
d) Are assessment periodically done? How often? Daily during infectious disease disasters? By whom? Healthcare professional on-site Designated, trained shelter worker		
e) Is there a system in place to assess and monitor illness among UC, staff, and volunteers? -Passive surveillance (e.g. self- report of symptoms) -Active surveillance for symptoms among well UC and staff (Get more description of this and how is this is done)		
f) Are UC and shelter workers encouraged to report symptoms of infectious diseases?		
g) Are there posters of reportable signs and symptoms/syndromes of potentially infectious diseases strategically located around the		

	shelter?		
h)	Shelter clinic keeps a daily log of conditions diagnosed onsite		
i)	Are Increases in rates of illness identified through syndromic surveillance investigated by the ICP/ICP designee on-site and the local health department?		
j)	Is there set "trigger points" in which shelter operations and/or changes in staffing must be considered prior to hitting a critical nature.		
	Hand hygiene (Ask HCW manager/staff)		
a)	The shelter provides supplies necessary for adherence to hand hygiene (e.g., soap, water, paper towels, alcohol-based hand rub) and ensures they are readily accessible to HCP in patient care areas		
b)	HCP are educated regarding appropriate indications for hand washing with soap and water versus hand rubbing with alcohol-based hand rub *Note: Soap and water should be used when bare hands are visibly soiled (e.g., blood, body fluids) or after caring for a patient with known or suspected infectious diarrhea (e.g., Clostridium difficile or norovirus). In all other situations, alcohol-based hand rub may be used.*		
c)	The facility periodically monitors and records adherence to hand hygiene and provides feedback to personnel regarding their performance		
	Personal Protective Equipment (Ask HCW manager/staff)		
a)	The facility has sufficient and appropriate PPE available and readily accessible to HCW		
b)	HCP receive training on proper selection and use of PPE		
	Injection Safety		
a)	Medication purchasing decisions at the facility reflect selection of vial sizes that most appropriately fit the procedure needs of the facility and limit need for sharing of multi-dose vials		
b)	Injections are required to be prepared using aseptic technique in a clean area free from contamination or contact with blood, body		

	fluids or contaminated equipment		
c)	Facility has policies and procedures to track HCP access to controlled substances to prevent narcotics theft/diversion		
	Respiratory Hygiene/Cough Etiquette (Ask HCW manager/staff, but also observe)		
a)	The facility has policies and procedures to contain respiratory secretions in persons who have signs and symptoms of a respiratory infection, beginning at point of entry to the facility and continuing through the duration of the visit. *Measures include:* *i. Posting signs at entrances (with instructions to patients with symptoms of respiratory infection to cover their mouths/ noses when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after hands have been in contact with respiratory secretions.)* *ii. Providing tissues and no-touch receptacles for disposal of tissues* *iii. Providing resources for performing hand hygiene in or near waiting areas* *iv. Offering facemasks to coughing patients and other symptomatic persons upon entry to the medical facility/shelter* *v. Providing space and encouraging persons with symptoms of respiratory infections to sit as far away from others as possible.* vi. *If available, facilities may wish to place these patients in a separate area while waiting for care*		
b)	Shelter clinic educates healthcare providers on the importance of infection prevention measures to contain respiratory secretions to prevent the spread of respiratory pathogens when examining and		

	caring for patients with signs and symptoms of a respiratory infection		
	Environmental Cleaning (Ask HCW manager/staff)		
a)	Facility has written policies and procedures for routine cleaning and disinfection of environmental services, including identification of responsible personnel		
b)	Environmental services staff receive job-specific training and competency validation at hire and when procedures/policies change		
c)	Training and equipment are available to ensure that HCP wear appropriate PPE to preclude exposure to infectious agents or chemicals (PPE can include gloves, gowns, masks, and eye protection)		
d)	Cleaning procedures are periodically monitored and assessed to ensure that they are consistently and correctly performed		
e)	The facility has a policy/procedure for decontamination of spills of blood or other body fluids		
	Reprocessing of Reusable Medical Devices		
a)	Facility has policies and procedures to ensure that reusable medical devices are cleaned and reprocessed appropriately prior to use on another patient		
b)	Policies, procedures, and manufacturer reprocessing instructions for reusable medical devices used in the facility are available in the reprocessing area(s)		
c)	HCP responsible for reprocessing reusable medical devices are appropriately trained and competencies are regularly documented (at least annually and when new equipment is introduced).		
d)	Training and equipment are available to ensure that HCP wear appropriate PPE to prevent exposures to infectious agents or chemicals (PPE can include gloves, gowns, masks, and eye protection). *Note: the exact type of PPE depends on infectious or chemical agent and anticipated type of exposure*		
	Sterilization of Reusable Instruments and Devices		
a)	All reusable critical instruments and devices are sterilized prior to		

	reuse		
b)	Routine maintenance for sterilization equipment is performed according to manufacturer instructions (confirm maintenance records are available)		
c)	Policies and procedures are in place outlining facility response (i.e., recall of device and risk assessment) in the event of a reprocessing error/failure.		
	High-Level Disinfection of Reusable Instruments and Devices		
d)	All reusable semi-critical items receive at least high-level disinfection prior to reuse		
e)	The facility has a system in place to identify which instrument (e.g., endoscope) was used on a patient via a log for each procedure		
f)	Routine maintenance for high-level disinfection equipment is performed according to manufacturer instructions; confirm maintenance records are available		
	Management of sick UC (Ask HCW manager/staff)		
a)	Shelter clinic has guidelines for referral and management of ill UC with specific conditions e.g. Influenza		
b)	Facility has adequate designated isolation areas for ill UC		
c)	An Isolation area is available for ill UC - Easily-cleanable? - Have separate toilets? - Separate hand-washing facilities?		
d)	There is adequate spatial separation at least 3 feet of space between sick individuals and adequate bed configuration(head to toe arrangement)		
e)	ILL UC are spatially separated from well UC until they are fever/symptom free for 24 hours?		
f)	Facility has guidelines for discharge of sick UC from Isolation back into dormitories?		
g)	There are postage to indicate that individuals should not enter isolation area without appropriate personal protective equipment (PPE)?		

h) Are there dedicated shelter staff (e.g., healthcare workers when available, housekeeping, custodial) to provide care for ill UC in isolation area?		
i) Are isolation staff restricted from working with non-infectious individuals in the shelter		
j) Are ill UC in isolation cohorted by disease/syndrome?		
k) Are the Isolation area doors or barriers kept closed?		
l) Does the isolation room have any specific air handling mechanism? e.g. airborne infection isolation room, negative pressure rooms/areas		
Section II: Personnel and Patient-care Observations		
Hand hygiene: Is Hand hygiene performed correctly		
a) Before contact with the patient or their immediate care environment (even if gloves are worn)		
b) Before exiting the patient's care area after touching the patient or the patient's immediate environment (even if gloves are worn)		
c) Before performing an aseptic task (e.g., insertion of IV or preparing an injection) (even if gloves are worn)		
d) After contact with blood, body fluids or contaminated surfaces (even if gloves are worn)		
e) When hands move from a contaminated-body site to a clean-body site during patient care (even if gloves are worn)		
Personal protective equipment is correctly used		
a) PPE is removed and discarded prior to leaving the patient's room or care area		
b) Hand hygiene is performed immediately after removal of PPE		
c) Gloves i) HCW wear gloves for potential contact with blood, body fluids, mucous membranes, non-intact skin, or contaminated equipment ii) HCW do not wear the same pair of gloves for the care of more than one patient iii) HCW do not wash gloves for the purpose of reuse		
d) Gowns: i. HCP wear gowns to protect skin and clothing during procedures or		

activities where contact with blood or body fluids is anticipated ii. HCP do not wear the same gown for the care of more than one patient		
e) Facial protection i) HCP wear mouth, nose, and eye protection during procedures that are likely to generate splashes or sprays of blood or other body fluids ii. HCP wear a facemask (e.g., surgical mask) when placing a catheter or injecting material into the epidural or subdural space (e.g., during myelogram, epidural or spinal anesthesia) iii) Are facemasks offered to coughing UC and shelter staff upon entry into the shelter? iv) Are sick UC provided appropriate PPE e.g. face masks outside of isolation areas?		
Injection Safety		
a) Needles and syringes are used for only one patient (this includes manufactured prefilled syringes and cartridge devices such as insulin pens)		
b) The rubber septum on a medication vial is disinfected with alcohol prior to piercing		
c) Medication vials are entered with a new needle and a new syringe, even when obtaining additional doses for the same patient		
d) Single dose (single-use) medication vials, ampules, and bags or bottles of intravenous solution are used for only one patient		
e) Medication administration tubing and connectors are used for only one patient		
f) Multi-dose vials are dated by HCP when they are first opened and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial Note: This is different from the expiration date printed on the vial.		
g) Multi-dose vials are dedicated to individual patients whenever possible.		
h) Multi-dose vials to be used for more than one patient are kept in a centralized medication area and do not enter the immediate patient		

treatment area (e.g.,. operating room, patient room/cubicle) *Note: If multi-dose vials enter the immediate patient treatment area they should be dedicated for single-patient use and discarded immediately after use.*		
i) All sharps are disposed of in a puncture-resistant sharps container		
j) Filled sharps containers are disposed of in accordance with state regulated medical waste rules		
k) All controlled substances (e.g., Schedule II, III, IV, V drugs) are kept locked within a secure area		
Point of Care Testing		
a) New single-use, auto-disabling lancing device is used for each patient *Note: Lancet holder devices are not suitable for multi-patient use*.		
b) If used for more than one patient, the point-of-care testing meter is cleaned and disinfected after every use according to manufacturer instructions *Note: If the manufacturer does not provide instructions for cleaning and disinfection, then the testing meter should not be used for >1 patient.*		
Environmental Cleaning		
a) Environmental surfaces, with an emphasis on surfaces in proximity to the patient and those that are frequently touched, are cleaned and then disinfected with an EPA-registered disinfectant		
b) Cleaners and disinfectants are used in accordance with manufacturer instructions (e.g., dilution, storage, shelf-life, contact time)		
Reprocessing of Reusable Instruments and Devices		
a) Reusable medical devices are cleaned, reprocessed (disinfection or sterilization) and maintained according to the manufacturer instructions. *Note: If the manufacturer does not provide such instructions, the device may not be suitable for multi-patient use.*		

b)	Single-use devices are discarded after use and not used for more than one patient. *Note: If the facility elects to reuse single-use devices, these devices must be reprocessed prior to reuse by a third-party reprocessor that it is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The facility should have documentation from the third party reprocessor confirming this is the case.*		
c)	Reprocessing area has a workflow pattern such that devices clearly flow from high contamination areas to clean/sterile areas (i.e., there is clear separation between soiled and clean workspaces)		
d)	Medical devices are stored in a manner to protect from damage and contamination		
	Sterilization of Reusable Instruments and Devices		
a)	Items are thoroughly pre-cleaned according to manufacturer instructions and visually inspected for residual soil prior to sterilization *Note: For lumened instruments, device channels and lumens must be cleaned using appropriately sized cleaning brushes*.		
b)	Enzymatic cleaner or detergent is used for pre-cleaning and discarded according to manufacturer instructions (typically after each use)		
c)	Cleaning brushes are disposable or cleaned and high-level disinfected or sterilized (per manufacturer instructions) after each use		
d)	After pre-cleaning, instruments are appropriately wrapped/packaged for sterilization (e.g., package system selected is compatible with the sterilization process being performed, hinged instruments are open, instruments are disassembled if indicated by the manufacturer)		
e)	A chemical indicator (process indicator) is placed correctly in the instrument packs in every load		
f)	A biological indicator is used at least weekly for each sterilizer and with every load containing implantable items		

g)	For dynamic air removal-type sterilizers, a Bowie-Dick test is performed each day the sterilizer is used to verify efficacy of air removal		
h)	Sterile packs are labeled with the sterilizer used, the cycle or load number, and the date of sterilization		
i)	Logs for each sterilizer cycle are current and include results from each load		
j)	After sterilization, medical devices and instruments are stored so that sterility is not compromised		
k)	Sterile packages are inspected for integrity and compromised packages are reprocessed prior to use		
l)	Immediate-use steam sterilization (flash sterilization), if performed, is only done in circumstances in which routine sterilization procedures cannot be performed		
m)	Instruments that are flash-sterilized are used immediately and not stored		
	High-Level Disinfection of Reusable Instruments and Devices		
a)	Flexible endoscopes are inspected for damage and leak tested as part of each reprocessing cycle		
b)	Items are thoroughly pre-cleaned according to manufacturer instructions and visually inspected for residual soil prior to high-level disinfection *Note: For lumened instruments, device channels and lumens must be cleaned using appropriately sized cleaning brushes.*		
c)	Enzymatic cleaner or detergent is used and discarded according to manufacturer instructions (typically after each use)		
d)	Cleaning brushes are disposable or cleaned and high-level disinfected or sterilized (per manufacturer instructions) after each use.		
e)	For chemicals used in high-level disinfection, manufacturer instructions are followed for: i. preparation ii. testing for appropriate concentration iii. replacement (i.e., prior to expiration or loss of efficacy)		

f)	If automated reprocessing equipment is used, proper connectors are used to assure that channels and lumens are appropriately disinfected		
g)	Devices are disinfected for the appropriate length of time as specified by manufacturer instructions		
h)	Devices are disinfected at the appropriate temperature as specified by manufacturer instructions		
i)	After high-level disinfection, devices are rinsed with sterile water, filtered water, or tap water followed by a rinse with 70% - 90% ethyl or isopropyl alcohol		
j)	Devices are dried thoroughly prior to reuse *Note: Lumened instruments (e.g., endoscopes) require flushing channels with alcohol and forcing air through channels.*		
k)	After high-level disinfection, devices are stored in a manner to protect from damage or contamination *Note: Endoscopes should be hung in a vertical position*		

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

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

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: _____

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

RAPID ENVIRONMENTAL HEALTH ASSESSMENT FOR UAC FACILITIES

I. ASSESSING AGENCY DATA

[1]Agency /Organization Name _____ [87]Immediate Needs Identified: ÿ Yes ÿ No

[2]Assessor Name/Title _____

[3]Phone __ __ __ - __ __ __ - __ __ __ __ [4]Email or Other Contact _____

II. FACILITY TYPE, NAME AND CENSUS DATA

[5]Shelter Type ÿ DOD ÿ Other ORR ÿ Other _____ [6]CBP Facility? ÿ Yes ÿ No ÿ Unk/NA [7]CBP Sector _____

[8]Date Shelter Opened __ __ /__ __/__ __ (mm/dd/yr) [9]Date Assessed __ __ /__ __/__ __ (mm/dd/yr) [10]Time Assessed __ __ : __ __ ÿ am ÿ pm

[11]Reason for Assessment ÿ Preoperational ÿ Initial ÿ Routine ÿ Other _____

[12]Location Name and Description _____

[13]Street Address _____

[14]City / County _____ [15]State __ __ [16]Zip Code __ __ __ __ __ [17]Latitude/Longitude _____/_____

[18]Facility Contact / Title _____ [19]Facility Type ÿ Barrack ÿ Open Area Structure ÿ Modular Temporary ÿ Other_____

[20]Phone __ __ __ - __ __ __ - __ __ __ __ [21]Fax __ __ __ - __ __ __ - __ __ __ __ [22]E-mail or Other Contact _____

[23]Current Census _____ [24]Estimated Capacity _____ [25]Size of Facility _____ [26]Number of Staff / Volunteers _____

III. FACILITY

[27]Structural damage	ÿ Yes	ÿ No	ÿ Unk/NA
[28]Security / law enforcement available	ÿ Yes	ÿ No	ÿ Unk/NA
[29]Water system operational	ÿ Yes	ÿ No	ÿ Unk/NA
[30]Hot water available	ÿ Yes	ÿ No	ÿ Unk/NA
[31]HVAC system operational	ÿ Yes	ÿ No	ÿ Unk/NA
[32]Adequate ventilation	ÿ Yes	ÿ No	ÿ Unk/NA
[33]Adequate space per person (20-40ft^2)	ÿ Yes	ÿ No	ÿ Unk/NA
[34]Free of injury /occupational hazards	ÿ Yes	ÿ No	ÿ Unk/NA
[35]Free of pest / vector issues	ÿ Yes	ÿ No	ÿ Unk/NA
[36]Acceptable level of cleanliness	ÿ Yes	ÿ No	ÿ Unk/NA
[37]Electrical grid system operational	ÿ Yes	ÿ No	ÿ Unk/NA
[38]Generator in use, [39] If yes, Type_____	ÿ Yes	ÿ No	ÿ Unk/NA
[40]Indoor temperature _____ ^oF			ÿ Unk/NA

IV. FOOD

[41]Preparation on site	ÿ Yes	ÿ No	ÿ Unk/NA
[42]Served on site	ÿ Yes	ÿ No	ÿ Unk/NA
[43]Safe food source	ÿ Yes	ÿ No	ÿ Unk/NA
[44]Adequate supply	ÿ Yes	ÿ No	ÿ Unk/NA
[45]Appropriate storage	ÿ Yes	ÿ No	ÿ Unk/NA
[46]Appropriate temperatures	ÿ Yes	ÿ No	ÿ Unk/NA
[47]Hand-washing facilities available	ÿ Yes	ÿ No	ÿ Unk/NA
[48]Safe food handling	ÿ Yes	ÿ No	ÿ Unk/NA
[49]Dishwashing facilities available	ÿ Yes	ÿ No	ÿ Unk/NA
[50]Clean kitchen area	ÿ Yes	ÿ No	ÿ Unk/NA

VIII. SOLID WASTE GENERATED

[66]Adequate num. receptacles (1/30-gx10 persons)	ÿ Yes	ÿ No	ÿ Unk/NA
[67]Appropriate separation	ÿ Yes	ÿ No	ÿ Unk/NA
[68]Appropriate disposal	ÿ Yes	ÿ No	ÿ Unk/NA
[69]Appropriate storage	ÿ Yes	ÿ No	ÿ Unk/NA
[70]Timely removal	ÿ Yes	ÿ No	ÿ Unk/NA
[71]Types ÿ Solid ÿ Hazardous ÿ Medical			ÿ Unk/NA

IX. CHILDCARE AREA

[72]Clean diaper-changing facilities	ÿ Yes	ÿ No	ÿ Unk/NA
[73]Hand-washing facilities available	ÿ Yes	ÿ No	ÿ Unk/NA
[74]Adequate toy hygiene	ÿ Yes	ÿ No	ÿ Unk/NA
[75]Safe toys	ÿ Yes	ÿ No	ÿ Unk/NA
[76]Clean food/bottle preparation area	ÿ Yes	ÿ No	ÿ Unk/NA
[77]Adequate child/caregiver ratio	ÿ Yes	ÿ No	ÿ Unk/NA
[78]Acceptable level of cleanliness	ÿ Yes	ÿ No	ÿ Unk/NA

X. SLEEPING AREA

[79]Adequate number of cots/beds/mats	ÿ Yes	ÿ No	ÿ Unk/NA
[80]Adequate supply of bedding	ÿ Yes	ÿ No	ÿ Unk/NA
[81]Bedding changed regularly	ÿ Yes	ÿ No	ÿ Unk/NA
[82]Adequate spacing (2.5 - 3 ft between cots)	ÿ Yes	ÿ No	ÿ Unk/NA
[83]Acceptable level of cleanliness	ÿ Yes	ÿ No	ÿ Unk/NA

XI. OTHER CONSIDERATIONS

[84]Handicap accessibility	ÿ Yes	ÿ No	ÿ Unk/NA
[85] UACs with functional needs present	ÿ Yes	ÿ No	ÿ Unk/NA
[86] Pregnant UAC present	ÿ Yes	ÿ No	ÿ Unk/NA

V. DRINKING WATER AND ICE				
[51]Adequate water supply	ÿ Yes	ÿ No	ÿ Unk/NA	
[52]Adequate ice supply	ÿ Yes	ÿ No	ÿ Unk/NA	
[53]Safe water source	ÿ Yes	ÿ No	ÿ Unk/NA	
[54]Safe ice source	ÿ Yes	ÿ No	ÿ Unk/NA	XII. COMMENTS *(List Critical Needs on Immediate Needs Sheet)*
VI. HEALTH / MEDICAL				
[55]Reported outbreaks	ÿ Yes	ÿ No	ÿ Unk/NA	
[56]Medical care services on site	ÿ Yes	ÿ No	ÿ Unk/NA	
[57]Mental health services available	ÿ Yes	ÿ No	ÿ Unk/NA	
VII. SANITATION				
[58]Adequate laundry services	ÿ Yes	ÿ No	ÿ Unk/NA	
[59]Adequate number of toilets (1/20 persons)	ÿ Yes	ÿ No	ÿ Unk/NA	
[60]Adequate number of showers (1/15)	ÿ Yes	ÿ No	ÿ Unk/NA	
[61]Adequate num. of hand-washing stations (1/15)	ÿ Yes	ÿ No	ÿ Unk/NA	
[62]Hand-washing supplies available	ÿ Yes	ÿ No	ÿ Unk/NA	
[63]Toilet supplies available	ÿ Yes	ÿ No	ÿ Unk/NA	
[64]Acceptable level of cleanliness	ÿ Yes	ÿ No	ÿ Unk/NA	
[65]Sewage system type	ÿ Community	ÿ On site	ÿ Portable	ÿ Unk/NA

SECTION B

1. Administrative Policies ,Shelter Practices and Education		
	Practice performed (Yes, No)	If answer is No, document plan for remediation
a) Are there written infection environmental health/infection control policies and procedures are available, current, and based on evidence-based guidelines (e.g., CDC/ HICPAC), regulations, or standards for: e.g. -Waste disposal including medical waste -Pest control -Sanitation		
b) Is there at least one individual trained in infection prevention or environmental health is employed by or regularly available to the facility?		
c) Does shelter have adequate supplies necessary for adherence to standard precautions readily available e.g. hand hygiene products, protective equipment, cleaning and disinfectant supplies?		
d) Do shelter staff and volunteers have received job-specific training on environmental health policies and procedures e.g. proper selection and use of PPE?		
Respiratory Hygiene/Cough Etiquette:		
e) Does the facility have policies and procedures to contain respiratory secretions in persons who have signs and symptoms of a respiratory infection, beginning at point of entry into the shelter? *Measures include :* *-Posting signs at entrances (with instruction to patients with symptoms of respiratory infections to cover their mouths/noses when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after hands have been in contact with respiratory secretions?* *-Provide tissues and no-touch receptacles for disposal of tissues* *-Provide resources for performing hand hygiene*		
Personal protective equipment		
f) Are facemasks offered to coughing UC and shelter staff upon entry into the shelter?		
g) Are shelter staff provided appropriate PPE when performing tasks : - Laundry collection and processing, - Food preparation and handling, -Waste collection and disposal		
h) Are PPEs stored appropriately?		
i) Are PPE e.g. masks worn appropriately/correctly?		

j) Is there a means of disposal of used PPE?		
5. Hand hygiene		
a) Are UC and staff are educated on hand washing with soap and water and use of alcohol hand gels? _ Educated on indications of alcohol based gels and use of water and soap?		
b) Do shelter staff monitor UC adherence/compliance to hand hygiene		
c) Is there hand hygiene signage at - shelter entrances, -washrooms, - isolation area -meal tents And hand hygiene stations?		
d) Are there hand hygiene facilities ; -In or just outside every isolation room/area -Near the restrooms - Near the food preparation and/or kitchen area - Near the eating area - At the entrance/exit of any common play areas/classroom/dormitories - As needed throughout the shelter		
6. Environmental Controls		
e) Are staffs trained in the management of spill involving potentially hazardous substance such as body fluids, and medical waste?		
f) Are staffs trained regarding PPE use and disposal to decrease skin exposure to harsh chemicals during cleaning and disinfection activities?		
g) Are environmental surfaces, (with an emphasis on surfaces in isolation spaces and medical facility and those that are frequently touched) cleaned and then disinfected with an EPA-registered disinfectant?		
h) How often does cleaning occur? -Bathroom areas should be cleaned daily and as necessary -Food preparation areas should be cleaned after each meal and as needed between food preparation tasks -Dining areas should be cleaned after each meal -Living and sleeping areas should be cleaned at least weekly and more often if necessary -Traffic flow patterns and use will determine the frequency these areas should be cleaned -Cots and assorted bedding should be cleaned and laundered between occupants and as needed when contaminated with body fluids		

-Medical/First aid or triage areas should be cleaned daily and as necessary -Isolation area should be cleaned daily, upon individual transfer to a medical facility or move to another part of the shelter, and as necessary		
i) Are cleaners and disinfectants are used in accordance with manufacturer instructions (e.g., dilution, storage, shelf-life, contact time)		
j) Are shelter employees are using appropriate PPE when cleaning or doing laundry		

SECTION C: List of Infection Prevention and Control Equipment/Supplies Needed for Shelters

Equipment	Present	Comments
-Red bags or containers for regulated medical waste disposal -Biohazard stickers or labels for regulated medical waste disposal -Sharps containers -Personal Protective Equipment (PPE) Respirators (N-95 or equivalent) Masks (surgical/procedure masks) Gowns (patient care gowns) Gloves (non-sterile procedure gloves) Eye protection (goggles or face shields) Hand hygiene products Alcohol Based Hand Rubs (ABHR) and dispensing system Soap (non-antimicrobial or anti-microbial) Paper towels Disinfectants Towelettes (antimicrobial wipes) Disinfectant (EPA-registered chemical germicide) Water Decontamination Products Chlorine or iodine tablets Non-scented household bleach (sodium hypochlorite) Wound Management Supplies Dressing materials (gauze, absorbent pads, tape, etc) Syndromic Surveillance Supplies Thermometers (disposable or supplies for disinfection between individuals) Sexually Transmitted Disease Prevention Supplies Barrier methods (condoms, dental dams, etc) Body Fluid Management Supplies Absorbent pads (blue pads) for incontinent individuals Diapers Impermeable sheets or pads for cots/sleeping area, when needed (based on ICP/ICP designee's recommendation) Facial tissues Environmental Controls Fans for creating negative pressure Plastic, drywall, or plywood for barrier creation Food Safety Thermometer for monitoring refrigerator/freezer and food		

temperature Vaccination Supplies Syringes Alcohol swabs		

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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: ____° 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: ____° 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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Human Parechovirus 3 (HPeV3) Investigation

Family Interview Questionnaire

Please note that this questionnaire has 17 pages and contains 8 parts:

Part A: Demographic information about the infant who was ill with HPeV3
Part B: Summary of mother's peripartum period
Part C: Summary of infant's illness with HPeV3
Part D: Review of infant's general health
Part E: Infant's surroundings and household contacts in the week before illness
Part F: Family and friend visits in the week before illness
Part G: Childcare or healthcare worker visits in the week before illness
Part H: Other information

Interview form for _____ (please insert infant's name)

Date of interview: _____ (MM/DD/YYYY)

Name of interviewer: _____

Interviewer's institution: _____

Primary interviewee (eg mother): _____

Phone number to call: _____ Home

_____ Cell

_____ Work

_____ Other

Secondary interviewee (eg father): _____

Phone number to call: _____ Home

_____ Cell

_____ Work

_____ Other

When initiating the interview, please use the following paragraph:

As we have previously discussed over the telephone, we are here today because we are investigating recent cases of infants diagnosed with parechovirus. We are working on this together with colleagues at Children's Mercy hospital, the CDC and the Kansas and Missouri state health departments. We are hoping to understand more about what happened around the time of the illness, and we hope that this will help us to understand parechovirus infections better and prevent future transmission.

Just to confirm, are you willing to speak with me today about this? ¨ Yes ¨ No

Final interview was conducted with: _____

Relationship to infant (case patient): _____

Part A: HPeV3 case-patient information

Infant's First Name: _____ ____

Infant's Last (Family) Name: _____

Date of Birth: _____ (MM/DD/YYYY) Sex: ¨ Female ¨ Male ¨ Unknown

First name of first parent/guardian: _____

Last (Family) name of first parent/guardian: _____

Email address: _____

Residence address: _____

_____

First name of second parent/guardian: _____

Last (Family) name of second parent/guardian: _____

Email address: _____

Residence address: _____

_____

Part B: Summary of mother's peripartum period

The questions below are directed towards the mother of the infant

Please adjust phrasing of questions according to who is being interviewed

I would first like to ask you a few questions about yourself and about the period of time from the week before birth up to when your son/daughter became ill.

What is your date of birth? _____ (MM/DD/YYYY) OR Age (years): _____

What is your occupation? _____

Did you have any non-pregnancy-related illnesses during this period? Anything from a mild cold to hospitalization is important here. (Cold, fevers, rashes, abdominal pain, diarrhea or vomitting). And can you remember when that occurred?
(if rash is mentioned, please ask for a detailed description – location, duration and general descriptors e.g. flat, raised, red, bumpy, scaly, blistering, fluid-filled blisters etc)

Did you seek medical care for any of these symptoms or illnesses at a doctor's office, clinic, urgent care center or hospital? ¨ Yes ¨ No

If yes, please describe:
(dates, hospital name, symptoms, admitted)

After the birth of your son/daughter, did you breastfeed him/her? ¨ Yes ¨ No

Has the baby been exclusively breast fed since birth? ¨ Yes ¨ No

If no, did you also use formula? ¨ Yes ¨ No

How often was formula used? _____

Are you currently still breastfeeding him/her? ¨ Yes ¨ No

If no, for how long did you breastfeed him/her? _____

Is there a family history of neurologic disorders, including seizures? ¨ Yes ¨ No ¨ Unknown

If yes, please describe:

Part C: Summary of infant's illness

I will now ask a few questions about your son's/daughter's illness.

Date of first symptoms: _____ (MM/DD/YYYY)

What symptoms did your son/daughter first show?

Please describe any other symptoms that followed and when they occurred:

Was he/she at home when the illness began? ¨ Yes ¨ No ¨ Unknown

If no, where was he/she? _____

Did you seek medical care for any of these symptoms at a doctor's office, clinic or urgent care center before your son/daughter was admitted to hospital? ¨ Yes ¨ No

If yes, please give details (where, when, name of physician etc): _____

_____

_____

_____

When did you take him/her to hospital? _____ (MM/DD/YYYY)

Hospital name: _____

Hospital floor and room number: _____

Admitting physician's name: _____

Were they transferred to another hospital? ¨ Yes ¨ No ¨ Unknown

If yes, transfer date: _____ (MM/DD/YYYY)

If yes, receiving hospital name: _____

If yes, doctor's name: _____

Part D: Review of infant's general health

Before your son/daughter became ill and required admission, was he/she on any medications?

Medication	For what reason?	Date Started (MM/DD/YYYY)	Date stopped (MM/DD/YYYY)

Before this illness, did you take your son/daughter to the hospital for any reason? ¨ Yes ¨ No

Before this illness, did you take your son/daughter to an outpatient clinic? ¨ Yes ¨ No

If yes to either, please describe (dates/hospitals/symptoms/providers):

Part E: Infant's surroundings and household contacts in the week before illness

I would now like to ask you some questions about who your son/daughter might have had close contact with in the week before their illness.

Does your infant (who was ill) attend day care? ¨ Yes ¨ No ¨ Unknown

If yes, please describe the frequency of attendance, location/setting, the approximate number of other children at the setting and the age of the other children at the setting:

If speaking to the mother, please skip to Person 2, under household contacts

Now I would like to ask you about the people who may have had contact with your child, starting with yourself:

Person 1

Name: _____

Age: _____ Relationship to infant: _____

Occupation: _____

Were you ill in the week before your son/daughter became ill? ¨ Yes ¨ No ¨ Unknown
(please ask specifically about respiratory and diarrheal symptoms)

If yes, what kind of symptoms did you have? _____

_____

_____

If yes, did you receive any treatment? _____

_____

_____

Household contacts

Could you now please describe the other members of your household, including both adults and children:

Person 2

Name: _____

Age: _____ Relationship to infant: _____

Occupation or school/preschool: _____

Were they ill in the week before your son/daughter became ill? ¨ Yes ¨ No ¨ Unknown
(please ask specifically about respiratory and diarrheal symptoms)

If yes, what kind of symptoms did they have? _____

_____

If yes, did they seek medical care and where? _____

_____

If yes, did they receive any treatment? _____

_____

Person 3

Name: _____

Age: _____ Relationship to infant: _____

Occupation or school/preschool: _____

Were they ill in the week before your son/daughter became ill? ¨ Yes ¨ No ¨ Unknown
(please ask specifically about respiratory and diarrheal symptoms)

If yes, what kind of symptoms did they have? _____

_____

If yes, did they seek medical care and where? _____

_____

If yes, did they receive any treatment? _____

_____

Person 4

Name: _____

Age: _____ Relationship to infant: _____

Occupation or school/preschool/day care: _____

Were they ill in the week before your son/daughter became ill? ¨ Yes ¨ No ¨ Unknown
(please ask specifically about respiratory and diarrheal symptoms)

If yes, what kind of symptoms did they have? _____

_____

If yes, did they seek medical care and where? _____

_____

If yes, did they receive any treatment? _____

_____

Person 5

Name: _____

Age: _____ Relationship to infant: _____

Occupation or school/preschool/day care: _____

Were they ill in the week before your son/daughter became ill? ¨ Yes ¨ No ¨ Unknown
(please ask specifically about respiratory and diarrheal symptoms)

If yes, what kind of symptoms did they have? _____

_____

If yes, did they seek medical care and where? _____

_____

If yes, did they receive any treatment? _____

_____

Person 6

Name: _____

Age: _____ Relationship to infant: _____

Occupation or school/preschool/day care: _____

Were they ill in the week before your son/daughter became ill? ¨ Yes ¨ No ¨ Unknown
(please ask specifically about respiratory and diarrheal symptoms)

If yes, what kind of symptoms did they have? _____

_____

If yes, did they seek medical care and where? _____

_____

If yes, did they receive any treatment? _____

_____

Person 7

Name: _____

Age: _____ Relationship to infant: _____

Occupation or school/preschool/day care: _____

Were they ill in the week before your son/daughter became ill? ¨ Yes ¨ No ¨ Unknown
(please ask specifically about respiratory and diarrheal symptoms)

If yes, what kind of symptoms did they have? _____

_____

If yes, did they seek medical care and where? _____

_____

If yes, did they receive any treatment? _____

_____

Part F: Family and friend visits in the week before illness

Were there any other family members or close friends who appeared unwell and who visited the infant in the week prior to onset of illness? Or that you went to visit? Please include children too.

Person 8

Name: _____

Age: _____ Relationship to infant: _____

Where did you see them? _____

Occupation or school/preschool/day care: _____

What kind of symptoms did they have? _____

_____

Did they seek medical care and where? _____

_____

Did they receive any treatment? _____

_____

Do you know if they had any ill family members or friends? ¨ Yes ¨ No ¨ Unknown
If yes, please include details in the next person below

Person 9

Name: _____

Age: _____ Relationship to infant: _____

Where did you see them? _____

Occupation or school/preschool/day care: _____

What kind of symptoms did they have? _____

_____

Did they seek medical care and where? _____

_____

Did they receive any treatment? _____

_____

Do you know if they had any ill family members or friends? ¨ Yes ¨ No ¨ Unknown
If yes, please include details in the next person below

Person 10

Name: _____

Age: _____ Relationship to infant: _____

Where did you see them? _____

Occupation or school/preschool/day care: _____

What kind of symptoms did they have? _____

_____

Did they seek medical care and where? _____

_____

Did they receive any treatment? _____

_____

Do you know if they had any ill family members or friends? ¨ Yes ¨ No ¨ Unknown
If yes, please include details in the next person below

Person 11

Name: _____

Age: _____ Relationship to infant: _____

Where did you see them? _____

Occupation or school/preschool/day care: _____

What kind of symptoms did they have? _____

_____

Did they seek medical care and where? _____

_____

Did they receive any treatment? _____

_____

Do you know if they had any ill family members or friends? ¨ Yes ¨ No ¨ Unknown
If yes, please include details in the next person below

Person 12

Name: _____

Age: _____ Relationship to infant: _____

Where did you see them? _____

Occupation or school/preschool/day care: _____

What kind of symptoms did they have? _____

_____

Did they seek medical care and where? _____

_____

Did they receive any treatment? _____

_____

Do you know if they had any ill family members or friends? ¨ Yes ¨ No ¨ Unknown
If yes, please include details in the next person below

Person 13

Name: _____

Age: _____ Relationship to infant: _____

Where did you see them? _____

Occupation or school/preschool/day care: _____

What kind of symptoms did they have? _____

_____

Did they seek medical care and where? _____

_____

Did they receive any treatment? _____

_____

Do you know if they had any ill family members or friends? ¨ Yes ¨ No ¨ Unknown
If yes, please continue overleaf

Part G: Childcare or healthcare worker visits in the week before illness

Were there any childcare or healthcare worker contacts who appeared unwell,in the week before illness? (e.g. babysitter, pediatric provider, lactation specialist)

Person 14

Name: _____

Age: _____ Relationship to infant: _____

Where did you see them? _____

Reason for visit:_____

What kind of symptoms did the visitor have? _____

_____

Did they seek medical care and where? _____

_____

Did they receive any treatment? _____

_____

Do you know if they had any ill family members or friends? ¨ Yes ¨ No ¨ Unknown
If yes, please include details in the next person below

Person 15

Name: _____

Age: _____ Relationship to infant: _____

Where did you see them? _____

Reason for visit:_____

What kind of symptoms did they have? _____

_____

Did they seek medical care and where? _____

_____

Did they receive any treatment? _____

_____

Do you know if they had any ill family members or friends? ¨ Yes ¨ No ¨ Unknown
If yes, please include details in the next person below

Person 16

Name: _____

Age: _____ Relationship to infant: _____

Where did you see them? _____

Reason for visit:_____

What kind of symptoms did they have? _____

_____

Did they seek medical care and where? _____

_____

Did they receive any treatment? _____

_____

Do you know if they had any ill family members or friends? ¨ Yes ¨ No ¨ Unknown
If yes, please include details in the next person below

Person 17

Name: _____

Age: _____ Relationship to infant: _____

Where did you see them? _____

Reason for visit:_____

What kind of symptoms did they have? _____

_____

Did they seek medical care and where? _____

_____

Did they receive any treatment? _____

_____

Do you know if they had any ill family members or friends? ¨ Yes ¨ No ¨ Unknown
If yes, please continue overleaf

Part H: Other information

Is there any other information that you feel may be important or unusual, with regard to your son's/daughter's illness or stay in hospital:

Thank you very much for taking the time to speak with me today. Your interview has been extremely useful and we hope it will help us to better understand the current situation.

We might need to contact you again in the future to ask some more questions about this. Would it be OK if I (or my colleagues) contacted you? ¨ Yes ¨ No

Collect diaper(s) if agreed.

Thank you very much for your help today.

End of interview form

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

Human Parechovirus 3 (HPeV3) Investigation

Medical Chart Abstraction Form

Please note that this medical chart review form has 19 pages and contains four parts:
Part A: **demographic information** about the infant who was ill with HPeV3
Part B: information from the medical chart of the **mother for labor, delivery and follow up**
Part C: information from the medical chart of the **infant during delivery and neonatal care**
Part D: information from the medical chart of the infant following **admission for HPeV3 illness (most likely at Facility A)**

Date of chart abstraction: _____ (MM/DD/YYYY)

Name of person completing form: _____

Name and address of institution where this form was completed:

_____

_____

Part A: HPeV3 case-patient information

First Name: _____ Last (Family) Name: _____

Date of Birth: _____ (MM/DD/YYYY) Sex: ¨ Female ¨ Male ¨ Unknown

Race: ¨ Asian ¨ Black or African American ¨ Native Hawaiian or Other Pacific Islander
¨ American Indian or Alaska Native ¨ White
(More than one box can be checked)

Ethnicity: ¨ Hispanic ¨ Non-Hispanic

First name of parent/guardian: _____

Last (Family) name of parent/guardian: _____

Contact telephone number: _____

Email address: _____

Residence address: _____

_____

Part B: Mother's medical record for labor, delivery and follow up

Medical record number: _____

Hospital name: _____

Hospital floor: _____ Hospital room number _____

Date mother was admitted to hospital: _____ (MM/DD/YYYY)

Date of discharge: _____ (MM/DD/YYYY)

Mother's First Name: _____

Mother's Last (Family) Name: _____

Mother's date of birth: _____ (MM/DD/YYYY) OR Mother's age (yrs) _____

Mother's race: ¨ Asian ¨ Black ¨ Hawaiian/Pacific Islander
¨ Native American/Alaskan ¨ White ¨ Other
(More than one box can be checked)

Mother's ethnicity: ¨ Hispanic ¨ Non-Hispanic

Mother's telephone number (if different to Part 1): _____

Mother's residence address (if different to Part 1): _____

_____

Mother's type of health insurance _____

Does the mother have any pre-existing medical conditions? ¨ Yes ¨ No ¨ Unknown

If yes, please describe:

Date of delivery: _____ (MM/DD/YYYY) Time of delivery: _____

Delivery ward: _____

Mode of delivery: ¨ Vaginal delivery ¨ Caesarean Section ¨ Unknown

If vaginal, duration of membrane rupture prior to delivery (hours) _____

Was a scalp monitor used during delivery? ¨ Yes ¨ No ¨ Unknown

If yes, was there evidence of its use upon physical examination? ¨ Yes ¨ No ¨ Unknown
(e.g. bruising, laceration)

Was the mother febrile (>38 °C) during delivery? ¨ Yes ¨ No ¨ Unknown

Was the mother febrile (>38 °C) in the week before delivery? ¨ Yes ¨ No ¨ Unknown

Did the mother have a rash during delivery? ¨ Yes ¨ No ¨ Unknown

Did the mother have a rash in the week before delivery? ¨ Yes ¨ No ¨ Unknown

If yes to any of the above, please include a description of the rash (eg location, type {maculopapular, vesicular} etc):

Please list any medications prescribed to the mother in hospital (e.g. PRN medications, oxytocin, antibiotics, anesthetics):

Medication	**Dose and route**	**Date Started (MM/DD/YYYY)**	**Date Stopped (MM/DD/YYYY)**

Medication	Dose and route	Date Started (MM/DD/YYYY)	Date Stopped (MM/DD/YYYY)

Please list staff present before and during labor or the delivery, and also post-partum care:

Name	Job Title

Any other comments regarding labor, delivery or post-partum care:

Part C: Infant's chart for delivery and neonatal follow up

Medical record number: _____

Hospital name: _____

Infant's First Name: _____ ____

Infant's Last (Family) Name: _____

Date of delivery: _____ (MM/DD/YYYY) Time of delivery: _____

Length of gestation (weeks): _____

Infant's Birth Weight (lbs): _____ ¨ Estimated ¨ Measured ¨ Unknown

Was resuscitation required at birth? ¨ Yes ¨ No ¨ Unknown

If yes: ¨ Suction ¨ Oxygen ¨ Positive pressure ventilation (PPV) ¨ Intubation

Which nursery was the infant in after birth? _____

How long was the infant in the nursery? _____ hours/days (please circle) ¨ Unknown

Please list any staff who cared for the infant in the nursery:

Name	**Job Title**

Please list any medications prescribed to the infant during neonatal care:

Medication	**Dose and route**	**Date Started (MM/DD/YYYY)**	**Date Stopped (MM/DD/YYYY)**

Please describe any treatment regimens or interventions provided to the infant during neonatal care (e.g. supplemental oxygen, respiratory therapy, supplemental feeding, circumcision, PRN meds etc):
Do not include intravenous fluids

Any other comments regarding the infant's delivery or neonatal care:

Discharge date: _____ (MM/DD/YYYY)

Status upon discharge: _____

_____

_____

Part D: Medical chart of infant's hospitalization for HPeV3 illness

Medical record number: _____

Infant's First Name: _____

Infant's Last (Family) Name: _____

Infant's date of birth: _____ (MM/DD/YYYY)

Date of testing for HPeV: _____(MM/DD/YYYY)

Test type: _____ Results: _____

Admission date to hospital of initial presentation: _____ (MM/DD/YYYY)

Transfer date from hospital of initial presentation: _____ (MM/DD/YYYY)

Admission date to secondary facility: _____ (MM/DD/YYYY)

Transferred from:

Hospital name and nursery: _____

Transferred to:

Hospital name and nursery: _____

Please describe any patient information available from a referring facility, if applicable:

Did the infant have any underlying medical conditions? ¨ Yes ¨ No ¨ Unknown

If yes, please describe:

Are outpatient visits prior to becoming ill noted in the chart? ¨ Yes ¨ No ¨ Unknown

If yes, please describe:

Is family history of neurologic illness, including seizures, noted in the chart? ¨ Yes ¨ No ¨ Unknown

If yes, please describe:

Please list any medications prescribed to the infant **before** hospitalisation (e.g. OTC meds used by parents, medications discontinued prior to hospitalisation):

Medication	**Dose and route**	**Date Started (MM/DD/YYYY)**	**Place of administration**

Signs and Symptoms

Date of first clinical symptoms: _____ (MM/DD/YYYY)

As part of this illness, does the infant have or has the infant had any of the following:

Fever

Fever (>38 °C)..... ¨ Yes ¨ No ¨ Unknown

If yes, what was the highest temperature? _____ °C

Temperature <35 °C..... ¨ Yes ¨ No ¨ Unknown

If yes, what was the lowest temperature? _____ °C

Rash

Skin rash..... ¨ Yes ¨ No ¨ Unknown

If yes, please describe (eg. Location, type {maculopapular, vesicular} etc):_____

_____

_____

Redness on feet or hands ..... ¨ Yes ¨ No ¨ Unknown

Ulcers or lesions in mouth..... ¨ Yes ¨ No ¨ Unknown

Neurologic

Focal seizures/convulsions..... ¨ Yes ¨ No ¨ Unknown

Generalized seizures/convulsions..... ¨ Yes ¨ No ¨ Unknown

Intractable seizures/convulsions..... ¨ Yes ¨ No ¨ Unknown

Myoclonic jerk..... ¨ Yes ¨ No ¨ Unknown

Tremors..... ¨ Yes ¨ No ¨ Unknown

Limb weakness/monoparesis..... ¨ Yes ¨ No ¨ Unknown

Stiff neck..... ¨ Yes ¨ No ¨ Unknown

Bulging fontanelle..... ¨ Yes ¨ No ¨ Unknown

Lethargy..... ¨ Yes ¨ No ¨ Unknown

Irritability..... ¨ Yes ¨ No ¨ Unknown

Inconsolable crying..... ¨ Yes ¨ No ¨ Unknown

Cranial nerve palsy..... ¨ Yes ¨ No ¨ Unknown

Respiratory

Cough (dry, productive)..... ¨ Yes ¨ No ¨ Unknown

Secretions..... ¨ Yes ¨ No ¨ Unknown

Runny nose..... ¨ Yes ¨ No ¨ Unknown

Sneezing..... ¨ Yes ¨ No ¨ Unknown

Difficulty breathing..... ¨ Yes ¨ No ¨ Unknown

Wheezing..... ¨ Yes ¨ No ¨ Unknown

Rales/crackles/crepitations..... ¨ Yes ¨ No ¨ Unknown

Tachypnea (as assessed and recorded by provider)... ¨ Yes ¨ No ¨ Unknown

If yes, please indicate rate _____ (RR/min)

Frothy secretions from mouth..... ¨ Yes ¨ No ¨ Unknown

Hemoptysis..... ¨ Yes ¨ No ¨ Unknown

Respiratory failure..... ¨ Yes ¨ No ¨ Unknown

Oxygen given..... ¨ Yes ¨ No ¨ Unknown

If yes, how was it administered? _____

Intubation..... ¨ Yes ¨ No ¨ Unknown

Retractions, nasal flaring..... ¨ Yes ¨ No ¨ Unknown

Cardiovascular

Bradycardia (as assessed and recorded by provider).. ¨ Yes ¨ No ¨ Unknown

If yes, please indicate rate _____ (HR/min)

Tachycardia (as assessed and recorded by provider).. ¨ Yes ¨ No ¨ Unknown

If yes, please indicate rate _____ (HR/min)

Variable heart rate (tachy/brady)..... ¨ Yes ¨ No ¨ Unknown

Cyanosis..... ¨ Yes ¨ No ¨ Unknown

Mottled skin..... ¨ Yes ¨ No ¨ Unknown

Arrhythmia..... ¨ Yes ¨ No ¨ Unknown

Abnormal heart sounds..... ¨ Yes ¨ No ¨ Unknown

If yes, please describe _____

Hypotension/shock..... ¨ Yes ¨ No ¨ Unknown

Gastrointestinal

Vomiting..... ¨ Yes ¨ No ¨ Unknown

Watery stools..... ¨ Yes ¨ No ¨ Unknown

Constipation..... ¨ Yes ¨ No ¨ Unknown

Abdominal distention..... ¨ Yes ¨ No ¨ Unknown

Abdominal pain..... ¨ Yes ¨ No ¨ Unknown

Jaundice..... ¨ Yes ¨ No ¨ Unknown

Poor feeding..... .. ¨ Yes ¨ No ¨ Unknown

Others

Conjunctivitis..... ¨ Yes ¨ No ¨ Unknown

Bleeding..... ¨ Yes ¨ No ¨ Unknown

Persistent crying..... ¨ Yes ¨ No ¨ Unknown

Lymphadenopathy..... ¨ Yes ¨ No ¨ Unknown

Please describe any other symptoms not listed above, or any of note:

Laboratory Exams

Please list here all laboratory findings from admission:

Specimen Collection Date (MM/DD/YYYY)	**Specimen type**	**Test type**	**Results (include reference range)**
	Serum	AST(SGOT), ALT(SGPT), GGT	
	Serum	T. BILI, direct bili	
	Serum	BUN, creatinine	
	Serum	Glucose	
	Serum	Creatinine Kinase	
	Serum	Sodium	
	Blood	HB/HCT	
	Blood	WBC	
	Blood	Neutros	

Specimen Collection Date (MM/DD/YYYY)	**Specimen type**	**Test type**	**Results (include reference range)**
	Blood	Bands	
	Blood	Lymphs	
	Blood	Monos	
	Blood	EOS	
	Blood	PLTS	
	Blood	Culture	
	Blood	ANC	
	Blood	LDH	
	Blood	CRP	
	Blood	ESR	
	NP/OP/Throat	Culture	
	Rectal/stool	Culture	
	Eye	Culture	
	Vesicle	Culture	
	Urine	Culture	
	Urine	UA	
	CSF	Opening pressure	
	CSF	RBC	
	CSF	WBC	
	CSF	Neutro	
	CSF	Lympho	
	CSF	EOS	

Specimen Collection Date (MM/DD/YYYY)	**Specimen type**	**Test type**	**Results (include reference range)**
	CSF	Protein	
	CSF	Glucose	
	CSF	Gram stain	
	CSF	Culture	
		HPeV3-specific PCR	
		Enterovirus-specific PCR	
		HSV-specific PCR	
		Other virus PCR	
Please describe below any other unusual laboratory results at admission			

Radiologic Exams

Please describe here all radiological exams requested:

Exam date (MM/DD/YYYY)	**Test type**	**Results**
	CXR	
	CT	
	MRI	
	Echocardiography	
	Ultrasound	
	EEG	
	Plain abdominal radiographs	

Medication and Treatment

Was the infant placed in the neonatal intensive care unit (NICU)? ¨ Yes ¨ No ¨ Unknown

If yes, admission date: _____ Discharge date: _____ (MM/DD/YYYY)

Was the infant placed in the pediatric intensive care unit (PICU)? ¨ Yes ¨ No ¨ Unknown

If yes, admission date: _____ Discharge date: _____ (MM/DD/YYYY)

Please list any medications prescribed to the infant in hospital:

Medication	**Dose and route**	**Date Started (MM/DD/YYY)**	**Date Stopped (MM/DD/YYY)**

Please describe any other treatment regimens or interventions provided to the infant in hospital (e.g. supplemental oxygen, respiratory therapy, supplemental feedings, PRN meds etc):
Do not include intravenous fluids

Discharge

Is infant still in hospital? ¨ Yes ¨ No If no, discharge date: _____(MM/DD/YYYY)

Status upon discharge: _____

Died: ¨ Yes ¨ No ¨ Unknown If yes, date of death _____ (MM/DD/YYYY)

Discharge diagnosis: _____

_____

_____

_____

_____

Other information

Please describe here any other information that you feel may be important or unusual, with regard to the infant's stay in hospital:

End of medical chart abstraction form

Form Approved
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Human Parechovirus 3 (HPeV3) Investigation

Patient and Sibling Diaper Collection Instrument

Variables Collected in Database:

MO/KS:

Specimen ID:

Name:

DOB:

Diagnosis Date:

Collection Date:

Comments:

HPeV result:

MS2 result:

Repeat Result:

Final Result:

Time between collection/diagnosis:

30 day collection:

60 day collection:

Call 1

Call 2

Call 3

Call 4

Call 5

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

Formulaire d'évaluation des Formations de Santé

Nom de l'évaluateur _____ Date de visite de la formation ____/_____/2014

Village/Ville _____ Zone de Santé _____

Informations Générales:

1. Type de Formation Sanitaire: ____Hôpital de Référence ____Centre de Santé ____Poste de Santé

2. Nombre approximatif de Villages/Villes desservis _____

Staff	**Nombre de chaque staff**	**Date de la dernière formation?** (Donner l'année)	**Durée de la dernière formation** (ex. 30mins)
Médecin			
Infirmier			
Sage-femme			
Relais communautaires			
Technicien de Labo			
Hygiéniste			
Educateur des masses			
Autre (s)			

3. Combien de fois la formation sanitaire est disponible/semaine? 1-2 fois 3-4 fois 5-6 fois Toujours
4. Nombre de patients desservis en moyenne/jour _____
5. **Ebola contrôle de l'Infection : Enumérer les éléments disponibles.**

Il y a :		Information complementaire
Une équipe designée pour prendre en charge les cas d'Ebola	Oui Non	
Un livre sur Ebola est disponible	Oui Non	
Un contact d'information avec le Médecin Chef de Zone (MCZ)	Oui Non	
Comment entre en contact avec le MCZ ?	NA	__Radiophonie __Téléphonee __Messenger _Autre _____
Information sur l'Ebola disponible sur papier/poster, etc.	Oui Non	
Vestiaire avec vêtements professionnels appropriés pour Ebola	Oui Non	
Aire d'isolement du patient	Oui Non	Si utilisée? ____Pièces séparées ____Bâtiments séparés
Restriction des visiteurs pour les patients d'Ebola	Oui Non	Citer les restrictions:
Séparation du matériel médical des patients Ebola	Oui Non	
Masques chirurgicaux pour patients Ebola	Oui Non	
Des toilettes séparées pour patients Ebola	Oui Non	
Un protocole de désinfection pour le matériel médical de réemploi	Oui Non	
Personnel choisi pour le nettoyage des pièces d'isolement	Oui Non	

Matériel de nettoyage séparé pour les patients Ebola (ex seau)	Oui Non	
Accès facile pour se laver (Mains)	Oui Non	
Capacité de transporter le patient à l'hôpital	Oui Non	
Ravitaillement/Equipement pour la surveillance d'Ebola	Oui Non	Nombre de ravitaillement au moment de la visite
Kit de prélèvement	Oui Non	
Matériel de cargaison pour les échantillons	Oui Non	
Formulaire de Surveillance	Oui Non	
Frigo fonctionnel	Oui Non	
Glaciaire/Boîtes pour transport des échantillons	Oui Non	

6.Equipement de protection personnelle	**Nombre d'équipement disponible lors de la visite**	**Source d'approvisionnement (cocher ce qui convient)**			**A quand remonte le dernier approvisionnement des articles**
		Gouvernement	**NGO**	**Autre**	
Gants (# de gants/cartons)					
Blouse jettable (usage unique)					
Masque à nez					
Lunettes					
Masques chirurgicaux					
Bottes en caoutchouc					
Savons					
Désinfectant (énumérer ci-bas)					

7. Disponibilté ou accès aux équipements énumérés ci-bas	
Téléphone	¨
Radiophonie	¨
Générateur d'électricité	¨
Panneau solaire avec batterie	¨
Ordinateur	¨

No. _____ *Form Approved; OMB No. 0920-1011; Exp Date: 03/31/2017*

RECO Interview

1. Aire de Santé: _____ Village: _____
   a. Nombre de population dans le village: _____ habitants
   b. Nombre des RECOs dans le village: _____
   c. Sexe: M F
   d. Age:_____ ans
   e. Niveau d'étude:_____
2. Depuis combien de temps etes-vous RECO? _____Mois/Annees
3. Comment vous etiez choisis comme RECO? _____
4. Quand aviez-vous appris de l'épidémie d'ebola?_____
5. Avez vous été formé sur ebola? _____
   a. Si oui, quand? _____ b. Par qui? _____
   Si non, c'est interessant? OUI NON

6. Avez-vous été appelés a aider pour un cas suspect Ebola? OUI NON
7. Si oui, où aviez-vous procuré les kits de protection? OUI NON
   a. Si oui, quels étaient les materiels compris? _____
   b. Avez-vous besoin d'utiliser ceux-là? OUI NON
      i. Si oui, dans quelle circonstance pourriez-vous les utiliser? _____

   _____

   c. Avez-vous été formé pour l'utilisation des kits de protection? OUI NON
   d. Pouvez-vous expliquer comment les utiliser ? _____

   _____

8. Avez vous fait le suivi des contacts? OUI NON
   a. Est-ce que vous etiez formé pour le suivi des contacts? OUI NON
      i. Si oui, par qui? _____
   b. Pouvez-vous m'expliquer pourquoi on suit les contacts? _____

   _____

   c. Que faites-vous si vous constatez que le contact a fait la fièvre? _____

   _____

9. Que pourriez-vous faire si vous decouvrez une personne malade dans la communauté, et vous pensez que ce peut etre Ebola? _____

   _____

   a. Qui pourriez-vous informer? _____
   b. Comment le contacter? _____

10. Est-ce-que vous etes informee des lieux ou communautes ou il y a Ebola? OUI NON
    a. Qui vous donne ces informations?

       _____
    b. Quand avez-vous recu les dernières informations? _____

11. Est-ce-que la population a peur ou s'inquiete d'ebola? OUI NON
    a. Si oui, que pensez-vous etre à la base des inquietudes de la communauté? (Etre malade, Etre dans le centre de santé en cas de maladie, Une famille qui tombe malade, Soutien financier familial, souffrance, autre à preciser)

       _____

       _____

12. Votre communauté a recu des messages en provenance d'une organisation pour se proteger elle meme contre Ebola? OUI NON
    a. Si **oui**, souviens-tu de cette organisation? _____
    b. Si **non**, est-ce-que c'est interressant pour la communauté? OUI NON
13. Que comprends-tu d'Ebola? _____

    _____

    _____

14. Comment quelqu'un peut-il attraper Ebola? _____

    _____

15. Où recevez-vous la rémunération pour votre travail? OUI NON
    a. Si oui, la quelle ou les quelles? _____
    b. C'est suffisant pour vous? OUI NON
       i. Pouquoi/Pourquoi pas?_____

C'est tout! Merci beaucoup!

CDC Patient ID: _____

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Chart Abstraction Form

Unique CDC Patient ID:_____

Patient Medical Record Number: _____

Patient Name : _____

DOB : _____

Facility:_____

Case Collection date (for cases) : _____

1. Is this patient a case or control? ☐ Case ☐ Control
2. Dialysis Facility: _____
3. Chart abstractor: ☐ CE ☐ ML ☐ KR ☐ PA ☐ SH ☐ Other:_____
4. Information abstracted from (check all that apply):
   ☐ Company EMR ☐ Other Company records
   ☐ Hospital records ☐ Reprocessing records
   ☐ Other: _____

Demographics

5. Age: _____
6. Sex: ☐M ☐F
7. Race (Select all that apply):
   ☐ American Indian/Alaska Native
   ☐ Asian
   ☐ Black or African American
   ☐ Native Hawaiian or Other Pacific Islander
   ☐ White
   ☐ Unknown
8. Ethnicity: ☐ Hispanic or Latino
   ☐ Non-Hispanic
   ☐ Unknown

Medical History

1. Date patient started ESRD __/___/___
2. Has patient had a kidney transplant? ☐ Y ☐ N
3. Date that patient started at Company A: _____

4. Is the patient still attending Company A Clinics for dialysis (check for end date)?

   ☐ Y ☐ N

5. Active dialysis access type(s) (check *all* that apply)

   ☐ Fistula date inserted: _____

   ☐ Graft date inserted: _____

   ☐ Catheter date inserted: _____

   ☐ Other (specify) _____

6. Comorbid Conditions:

   ☐ Diabetes, DM ☐ Hypertension, HTN ☐ Congestive Heart Failure

   ☐ Coronary artery disease, CABG, ASHD ☐ HIV / AIDS

   ☐ Peripheral vascular disease, PVD or PAD ☐ Anemia

   ☐ Cerebrovascular disease, TIA, stroke ☐ Malnutrition, wasting

   ☐ Cirrhosis, End-stage liver disease ☐ Hepatitis C, HCV

   ☐ Hepatitis B, HBV ☐ Immunocompromised

   ☐ Other, specify: _____

7. Has this patient had a BSIs occurring after Sept1, 2012?

   ☐ Yes ☐ No

8. Has this patient had an access site infections occurring after Sept1, 2012?

   ☐ Yes ☐ No

9. Has this patient had other relevant infections since Sept1, 2012?

   ☐ Yes ☐ No

10. If “Yes” to either 10, 11, or 12, list organisms and dates below (since Sept 1, 2012)

Type/source	Organism	date	antibiotics given?
_____			☐ Yes ☐ No
_____			☐ Yes ☐ No
_____			☐ Yes ☐ No
_____			☐ Yes ☐ No

Systemic Medications:

11. ☐ Coumadin/Warfarin ☐ Low Molecular Weight Heparin (Lovenox)
12. ☐ Aspirin ☐ Other anticoagulant, specify _____
(Dabigatran/Paradaxa) (Rivaroxaban/Xarelto) (Apixaban/Eliquis) (Plavix/Clopidogrel)
13. ☐ Immunosuppressant medication, specify _____

Pre-dialysis, Dialysis and Post-Care

14. Access preparation, select one:

☐ Alcohol
☐ Antimicrobial Soap and Water Wash
☐ ChloraScrub
☐ ExSept Plus
☐ Other
☐ Shur-Clens
☐ Betadine
☐ ChloraPrep
☐ Chlorhexidine
☐ Hibiclens
☐ Phisohex

15. Anesthetic used:

☐ Procaine ☐ EMLA Cream

☐ None ☐ Other

☐ Xylocaine ☐ Lidocaine

☐ Ethyl Chloride Spray

16. Dialysis access type used for this dialysis session (check *only* one):

☐ Fistula ☐ Graft ☐ Catheter

☐ Other (specify) _____

17. Date of session: _____

18. Dialysis session number: _____

19. Day of Session: _____

20. Dialysis station: _____

21. Dialysis machine number: _____

22. Shift of session: _____

23. Unit\Room: _____

24. Dialyzer type/Brand:

☐ Exeltra 150	☐ Optiflux F160NR	☐ Optiflux 200NR
☐ Exeltra NR 150	☐ Optiflux F180A	☐ Optiflux 250NR
☐ Exeltra Plus 210	☐ Optiflux F180NR	☐ Revaclear Max
☐ Gambro Polyflux 24R 1240	☐ Optiflux F200A	☐ Rexeed 25R

25. Dialyzer confirmed: ☐ Yes ☐ No

26. Manufacturer label intact/legible: ☐ Yes ☐ No

27. Integrity/appearance intact: ☐ Yes ☐ No

28. Sterliant present: ☐ Yes ☐ No

29. Reusable label legible/intact/complete: ☐ Yes ☐ No

30. Dry pack: ☐ Yes ☐ No

31. Did the patient show signs/symptoms of infection during dialysis sessions in the last week prior to this session? ☐ Yes ☐ No

32. Was this a reusable dialyzer? ☐ Yes ☐ No

If YES to reuse dialyzer,

a. Was this the first time the dialyzer was used? ☐ Y ☐ N ☐ Unknown

b. Was dialyzer reprocessed prior to this use? ☐ Y ☐ N ☐ Unknown

If YES,

i. Date last reprocessed: Date:____/_____/_____ Time: _____

33. Usage count: _____

34. Has the patient received antibiotics in the week prior to session? ☐ Yes ☐ No

35. Has the patient missed any sessions in week prior to session? ☐ Yes ☐ No

If yes, select reasons (on following page):

☐ Out of town ☐ Illness, not requiring hospitalization

☐ Hospitalization ☐ Unknown

☐ personal reason ☐ Access problem ☐ Other

36. Has the patient been hospitalized in the week prior to session? ☐ Yes ☐ No

a. If Yes, was the reason for hospitalization due to infection? ☐ Yes ☐ No

37. Any symptoms ***before*** dialysis started?:

☐ Yes ☐ No ☐ Unknown

a. If Yes, check all that apply:

☐ Fever (>100F then Tmax: _____) ☐ nausea/vomiting

☐ Chills/cold ☐ Low blood pressure (<100/60)

☐ Other: _____

b. If Yes, date symptoms started_____

38. Start time of dialysis:_____

39. End time of dialysis:_____

40. Did any events occur ***during*** dialysis?: ☐ Y ☐ N

a. If Yes, check all that apply:

☐ Fever(>100F, Tmax: _____) ☐ nausea/vomiting

☐ Chills/cold ☐ Low blood pressure (<100/60)

☐ Equipment Malfunction(s): _____

☐ Other: _____

41. If Yes, was dialysis discontinued prematurely?

☐ Y ☐ N ☐ Unknown

42. Did any events occur ***post-***dialysis?: ☐ Y ☐ N

a. If Yes, check all that apply:

☐ Fever (>100F, Tmax: _____)

☐ nausea/vomiting

☐ Chills/cold

☐ Low blood pressure (<100/60)

☐ Other: _____

b. If Yes, date symptoms started_____

43. Describe post-dialysis access care (Dressing type or ointment used, etc.)

a. Was a new dressing applied: ☐ Y ☐ N ☐ Unknown

44. Was patient sent to a hospital directly after this dialysis session?
(check patient status under patient log post-dialysis)

☐ Y ☐ N

Hospital Name/Location: _____

a. Was the reason for hospitalization related to infection?

☐ Y ☐ N ☐ Unknown

45. Were blood cultures ordered (orders on left menu)?

☐ Yes ☐ No

a. If Yes, why were the blood cultures ordered

☐ clinical symptoms of infection

☐ follow-up from prior infection/hospitalization

☐ other, specify

46. Parenteral Medications/infusates given during dialysis: *(visit log, orders)*

Epogen	☐ Yes ☐ No	Aranesp	☐ Yes ☐ No
Zemplar	☐ Yes ☐ No	Ferrlecit	☐ Yes ☐ No
Heparin	☐ Yes ☐ No	Hecterol	☐ Yes ☐ No
Saline Flush	☐ Yes ☐ No	Calcium	☐ Yes ☐ No

Antibiotics (list): ☐ Yes ☐ No

_____

_____

Other IV/IM medications (list):

_____

47. Was antimicrobial ointment applied: ☐ Y ☐ N ☐ Unknown

a. If yes, describe: _____

Reprocessing Information

48. Was the header removable? ☐ Y ☐ N

49. Who was the person who reprocessed it (NOT in SPIN): _____

50. Renatron machine number: _____

51. Was reprocessing done on-site (NOT in SPIN)?

☐ Y ☐ N ☐ Unknown

a. If No, List location _____

52. Regarding the following questions:

a. Was the dialyzer preprocessed? ☐ Y ☐ N ☐ Unknown

b. Did the patient give consent for dialyzer reuse? ☐ Y ☐ N ☐ Unknown

c. Was dialyzer refrigerated before most recent reprocessing?

☐ Y ☐ N ☐ Unknown

a. Was dialyzer stored after reprocessing? ☐ Y ☐ N ☐ Unknown

b. Was a germicide check documented? ☐ Y ☐ N ☐ Unknown

Outcome Information

53. Collection date of first positive culture meeting case definition:_____

    a. Culture results:

    ☐ B. cepacia ☐ P. aeruginosa

    ☐ R. pickettii ☐ S. maltophilia

    ☐ Other organism (list): _____

54. Was patient started on antibiotics within 1 week after blood draw or immediately upon display of signs and symptoms?

    ☐ Y ☐ N ☐ Unknown

    If Yes,

    a. List additional antibiotics
       (Name / Start Date/Time)

       i. _____

       ii. _____

55. Was the patient admitted to the hospital within 1 week of culture results/draw?

    ☐ Y ☐ N

If YES, answer the following questions related to that hospitalization:

a. Name of hospital: _____

b. If yes, to what kind of ward? ☐ ICU ☐ non-ICU ward ☐ Unknown

c. Admission date: _____ to Discharge date:_____

d. Was the reason for admission related to infection? ☐ Y ☐ N

e. Did the patient develop sepsis / hypotension requiring pressors: ☐ Y ☐ N

56. Deceased: ☐ Yes ☐ No

    a. If Yes, date of death: _____

57. Other outcomes:

☐ Catheter infected ☐ Graft infected

☐ Catheter removed ☐ Graft removed

☐ Others: _____

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Reuse and Reprocessing Checklist

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Reuse and Reprocessing Checklist

Note with a G when a glove change occurs

Note with an H when hand hygiene happens

Initial Steps

1. Put on PPE
2. Perform hand hygiene and put on gloves
3. Cut the venous line 1 to 2 inches above the venous drip chamber and discard the arterial blood line
4. Place the dialyzer in the holder above the reuse sink with a blood line secured and free of kinks
5. Remove port caps
    a. Are caps placed immediately into disinfectant for later reuse?
    b. Was a weight insert used to ensure the caps are totally immersed?
6. Connect the dialysate RO water line to the lower dialysate port
7. Connect the tubing segment to the upper dialysate port, near the venous header
8. Turn the dialysate RO water switch on

Next steps (note the order of operations, which is done first, header cleaning or reverse ultrafiltration?: _____

1. Put on PPE
2. Perform hand hygiene and put on gloves
3. Stop the flow of water going through the venous dialysate port to begin reverse ultrafiltration (attach a plug to the Hansen connector)
4. Leave the dialyzer under reverse ultrafiltration until the water exiting the dialyzer is clear

5. Turn the dialysate RO water switch OFF and release the pressure from the dialysate compartment
6. Remove lower dialysate RO line and return to panel
7. Remove the header cap using only AAMI standard RO water to facilitate the removal of blood clots or rinse header areas
    a. Are they manually cleaning the header with wipes or a cloth?
    b. Are they manually cleaning the o ring with wipes or a cloth?
    c. Did they perform this process for both headers?
    d. Was the uncapped dialyzer end dipped into the disinfectant solution (Fresenius best practices)?
8. Once the header caps have been cleaned, the cap and o-ring must be separate and immersed in a 1% peracidin solution
    a. Were headers or o-rings from multiple dialyzers placed into the same disinfectant solution simultaneously?
    b. Did the tech ensure the entire header cap and o-ring was submerged? (no floating pieces)
9. While insuring proper o ring alignment, reassemble the header caps
    a. Did they rinse off either the header or O-rings prior to re-assembly?
    b. Were the headers and O-rings placed back on their respective dialyzers?
    c. Are they using a wrench to tighten the header cap?
    d. What is the orientation of the dialyzer during recapping (uncapped end facing up or down, Fresenius best practices)?

Remaining Cleaning

10. Using a disinfected segment, connect the RO water line to the arterial blood port and turn the water ON.
11. Stop the flow of water going into the blood compartment and clamp the tubing from the venous blood port
12. Re-attach the venous blood tubing to the top of the dialyzer venous blood port
13. Remove the RO line from the arterial blood port and allow fluid to drain from the arterial blood port
14. Was the dialyzer wiped with bleach wipe thoroughly before being placed in the holding station?

Post-Renatron Storage

1. Was the dialyzer capped using caps cleaned in disinfectant?
2. Was the dialyzer stored in the cubby hole with the dialysate ports facing up?

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BRAIN MRI FINDINGS	
MRN Number	Click here to enter text.
What date did the neurologic symptoms onset?	Click here to enter a date.
Was this patient a case?	Choose an item.
Was a brain MRI performed?	Choose an item.
Did the brain MRI show a supratentorial lesion?	Choose an item.
Did the brain MRI show a brainstem lesion(s)?	Choose an item.
Did the brain MRI show a midbrain lesion(s)?	Choose an item.
Did the brain MRI show a pons lesion(s)?	Choose an item.
Did the brain MRI show a dorsal pons lesion(s)?	Choose an item.
Did the brain MRI show a medulla lesion	Choose an item.
Did the brain MRI show any other cerebellar lesion(s)?	Choose an item.
Did the brain MRI show a cranial nerve lesion(s)?	Choose an item.
Please describe any additional comments regarding the MRI of the brain:	
Click here to enter text.	

NEURORADIOLOGICAL FINDINGS

CERVICAL-THORACIC MRI FINDINGS	
Was a CT spine MRI performed?	Choose an item.
What date as the CT spine MRI performed?	Choose an item.
Did the CT spine MRI show multilevel poliomyelitis?	Choose an item.
Did the CT spine MRI show a conus lesion(s)?	Choose an item.
Please describe any additional comments regarding the MRI of the CT spine:	

LUMB AR MRI FINDINGS	
Was a L spine MRI performed?	Choose an item.
What date was the L spine MRI performed?	Choose an item.
Did the L spine MRI show a ventral nerve root enhancement?	Choose an item.
Please describe any additional comments regarding the MRI of the L spine:	
Click here to enter text.	

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DEMOGRAPHIC INFORMATION	
MRN	Click here to enter text.
Date of Neurologic Symptom Onset	Click here to enter a date.
Patient's Age	Click here to enter text.
Age Units	Choose an item.
Patient's Sex	Choose an item.
Patient's Race	Choose an item.
Patient's Ethnicity	Choose an item.
Patient's residential zip code	Click here to enter text.

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CLINICAL SYMPTOMS (PRE-NEUROLOGIC ONSET)**MRN**	Click here to enter text.
Date of onset of neurologic symptoms	Click here to enter a date.
What was the patient's past medical history?	Choose an item.
Did the patient take any chronic medications?	Choose an item.
Did the patient have chronic immunocompromised medications?	Choose an item.
If the patient took chronic medications, please describe:	
Click here to enter text.	
Did the patient have any pets in their home?	Choose an item.
Did the patient travel outside of their state in the last month?	Choose an item.
Did the patient have a wilderness exposure in the last month?	Choose an item.
If the patient travelled outside their state in the last month, what was their travel destination? (city, state, country)	Choose an item.
Was the patient vaccinated for polio?	Choose an item.
Did the patient receive any vaccinations in the last month?	Choose an item.
Please specify, if the patient received any vaccinations in the last month:	
Click here to enter text.	
Did the patient have a previous acute illness in the past month?	Choose an item.
If patient had a previous acute illness, what was the date did the illness onset?	Choose an item.

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CLINICAL SYMPTOMS CONTINUED

Did the patient have a fever (>38.0)?	Choose an item.
What was the patient's highest temperature?	Click here to enter text.
Describe acute illness: Fatigue?	Choose an item.
Describe acute illness: Headache?	Choose an item.
Describe acute illness: Photphobia?	Choose an item.
Describe acute illness: Red eyes?	Choose an item.
Describe acute illness: Ear pain?	Choose an item.
Describe acute illness: Runny nose?	Choose an item.
Describe acute illness: Cough?	Choose an item.
Describe acute illness: Shortness of breath?	Choose an item.
Describe acute illness: Sores around the pharynx?	Choose an item.
Describe acute illness: Sores Throat?	Choose an item.
Describe acute illness: Abdominal pain?	Choose an item.
Describe acute illness: Nausea/Vomitting?	Choose an item.
Describe acute illness: Anorexia?	Choose an item.
Describe acute illness: diarrhea?	Choose an item.
Describe acute illness: Rash?	Choose an item.
Describe acute illness: Generalized muscle pain?	Choose an item.
Describe acute illness: joint pain?	Choose an item.
Describe acute illness: neck pain?	Choose an item.
Describe acute illness: back pain?	Choose an item.
Describe acute illness: arm pain?	Choose an item.
Describe acute illness: leg pain?	Choose an item.
Medication for acute illness: acetaminophen	Choose an item.
Medication for acute illness: NSAIDS	Choose an item.
Medication for acute illness: albuterol	Choose an item.
Medication for acute illness: corticosteroids	Choose an item.
Medication for acute illness: please specify corticosteroids	Choose an item.
Medication for acute illness: antibiotics	Choose an item.
Medication for acute illness: please specify antibiotics	Choose an item.
Time between acute illness and neurologic onset (days)	Choose an item.

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NEUROLOGIC SYMPTOMS

Medical Record Number: Click here to enter text.

Date of neurologic symptom onset : Click here to enter a date.

Please describe initial neurologic symptoms:

Click here to enter text.

Did the patient experience any of the following at onset of neurologic symptoms?

Altered mental status:	Unknown	**Diplopia:**	Choose an item.		
Abnormal nystagmus:	No	**Increased reflexes:**	Choose an item.		
Facial weakness:	Choose an item.	**Neck pain:**	Choose an item.	**Spasticity:**	Choose an item.
Palatal weakness:	Choose an item.	**Back pain:**	Choose an item.	**Upgoing toes:**	Choose an item.
Tongue weakness:	Choose an item.	**Arm pain:**	Choose an item.	**Ataxia:**	Choose an item.
Neck weakness:	Choose an item.	**Leg pain:**	Choose an item.	**Myoclonus:**	Choose an item.
Respiratory weakness:	Choose an item.	**General numbness:**	Choose an item.	**Difficulty walking:**	Choose an item.
Arm weakness:	Choose an item.	**Face numbness:**	Choose an item.		
Leg weakness:	Choose an item.	**Arm numbness:**	Choose an item.		
Bowel incontinence:	Choose an item.	**Leg numbness:**	Choose an item.		
Bladder incontinence:	Choose an item.	**Sensory level numbness:**	Choose an item.		

Date of Nadir: Click here to enter a date.

Please describe neurologic symptoms at nadir:

Click here to enter text.

Did the patient experience any of the following neurologic symptoms at nadir?

Altered mental status:	Choose an item.	**Diplopia:**	Choose an item.		
Abnormal nystagmus:	Choose an item.	**Increased reflexes:**	Choose an item.	**Spasticity:**	Choose an item.
Facial weakness:	Choose an item.	**Neck pain:**	Choose an item.	**Upgoing toes:**	Choose an item.
Palatal weakness:	Choose an item.	**Back pain:**	Choose an item.	**Ataxia:**	Choose an item.
Tongue weakness:	Choose an item.	**Arm pain:**	Choose an item.	**Myoclonus:**	Choose an item.
Neck weakness:	Choose an item.	**Leg pain:**	Choose an	**Difficulty**	Choose an

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			item.	**walking:**	item.
Respiratory weakness:	Choose an item.	**General numbness:**	Choose an item.		
Arm weakness:	Choose an item.	**Face numbness:**	Choose an item.		
Leg weakness:	Choose an item.	**Arm numbness:**	Choose an item.		
Bowel incontinence:	Choose an item.	**Leg numbness:**	Choose an item.		
Bladder incontinence:	Choose an item.	**Sensory level numbness:**	Choose an item.		

PERSISTENT NEUROLOGIC SYMPTOMS

Have upper motor neuron symptoms resolved? Choose an item.

Date first noticed upper motor neuron symptoms resolved: Choose an item.

Was the patient hospitalized? Choose an item.

Date of hospital admission: Click here to enter a date. **Date of discharge:** Click here to enter a date.

Was the patient admitted to the ICU? Choose an item.

Date of ICU admission Click here to enter a date. **Date of ICU discharge:** Click here to enter a date.

Was the patient intubated? Choose an item.

Date patient was intubated: Click here to enter a date. **Date patient was extubated:** Click here to enter a date.

Did patient receive corticosteroids for neurologic symptoms? Choose an item. **Date received steroids:** Click here to enter a date.

Plasma exchange for neurologic symptoms: Choose an item. **Start date of plasma exchange:** Click here to enter a date.

Did the patient receive IVIG for neurologic symptoms? Choose an item. **Start date of IVIG:** Click here to enter a date.

Did the patient receive an experimental drug for neurologic symptoms?: Choose an item.

State date of Experimental drug: Click here to enter a date.

Please specify which experimental drugs were given: Choose an item.

EMG Done: Choose an item. **EMG Date:** Click here to enter a date.

Specify results of EMG: Click here to enter text.

Latest/Current status: Click here to enter text.

Date of status Update: Click here to enter a date.

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Patient Name: _____

CDC ID#:_____

Appendix 1: Chart Abstraction Form CDC ID: _____

Form Approved
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Exp. Date 03/31/2017

Chart Abstraction Form

Name of Person Completing Form _____ Date: ____/_____/____

☐ Case ☐ Control: Matched to case (CDC ID): _____

Date of specimen collection with first positive *Pseudomonas aeruginosa* culture ("**onset date**") (for case or matched control): _____

30 day window period: _____ to _____ (onset date)

7 day window period: _____ to _____ (onset date)

☐ Surveillance culture; Source _____

☐ Clinical culture; Source _____

Pseudomonas Specimen Susceptibility

Antibiotic	Sensitivity (Susceptible=S, Resistant=R)
Aztreonam	
Cefepime	
Ceftazidime	
Ciprofloxacin	
Gentamicin	
Imipenem	
Meropenem	
Pipercillin+Tazobactam	

A. Demographic Information

Sex: ☐ Male ☐ Female Day of life at onset date:_____

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander ☐ Other_____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

B. Birth History

Gestational age: ____ wks ____ days Birth weight: _____ grams or _____lbs.____oz.

Birth: ☐ C-section ☐ Vaginal delivery ☐ Multiple birth ☐ Assisted delivery: Forceps/vacuum

APGAR: 1min____ 5 min____

C. Maternal/ Obstetric History: G____P____

- ☐ Chorioamnionitis
- ☐ Cigarette smoking
- ☐ Drug use:_____
- ☐ Fetal distress
- ☐ Gestational diabetes
- ☐ IUGR
- ☐ Maternal infection (within 3 days prior to delivery)
- ☐ Preeclampsia
- ☐ Premature ROM
- ☐ Prolonged ROM
- ☐ No prenatal care
- ☐ Unknown
- ☐ Other_____

D. Medical History

1. Comorbidities within *7 days* prior to onset date: ☐ Unknown

- ☐ Aspiration
- ☐ Gastric residual >30%
- ☐ Intracran. hemorrhage
- ☐ Patent ductus arteriosis
- ☐ Perinatal asphyxia
- ☐ Reflux/ Regurgitation
- ☐ Cardiac abnormalities (e.g., congenital heart disease): _____
- ☐ Pulmonary disease (e.g., BPD, HMD/RDS, meconium aspiration): _____
- ☐ Gastointestinal disease (e.g., NEC, gastroschisis, omphalocele): _____
- ☐ Other: _____

2. Did infant have any of the following within *7 days* prior to onset date? ☐ Unknown

- ☐ GI surgery
- ☐ Non GI surgery (specify: _____)
- ☐ Retinopathy of prematurity (ROP) treatment
- ☐ Eye exam
- ☐ Oro/nasogastric tube
- ☐ G-tube
- ☐ Jejunal tube
- ☐ Supplemental O2
- ☐ CPAP or BiPAP (non-invasive)
- ☐ Other devices (not captured in Tables 4 or 5 below; specify): _____

E. Medication/Device History

1. Was infant treated with any systemic antimicrobials within 30 days prior to onset date?
   ☐ Yes ☐ No ☐ Unk

Antimicrobial	Route	Start Date(s)	Stop Date(s)

2. Other medications received within 7 days prior to onset date?

Medication	Route	Mixed with water?*	Start Date(s)	Stop Date(s)
		☐ Yes ☐ No ☐ Unk *Source: _____		
		☐ Yes ☐ No ☐ Unk *Source: _____		
		☐ Yes ☐ No ☐ Unk *Source: _____		
		☐ Yes ☐ No ☐ Unk *Source: _____		
		☐ Yes ☐ No ☐ Unk *Source: _____		
		☐ Yes ☐ No ☐ Unk *Source: _____		
		☐ Yes ☐ No ☐ Unk *Source: _____		

3. Other injectables received within 7 days prior to onset date?

Product	Receipt	Start Date(s)	Stop Date(s)
TPN	☐ Yes ☐ No ☐ Unk		
Lipids	☐ Yes ☐ No ☐ Unk		
Maintenance Fluids	☐ Yes ☐ No ☐ Unk		
	☐ Yes ☐ No ☐ Unk		
	☐ Yes ☐ No ☐ Unk		
	☐ Yes ☐ No ☐ Unk		

4. Catheter within 7 days prior to onset date?

Catheter type	Presence	Start Date(s)	Stop Date(s)
Umbilical catheter	☐ Yes ☐ No ☐ Unk		
PICC line	☐ Yes ☐ No ☐ Unk		
Other central venous catheter (specify:	☐ Yes ☐ No ☐ Unk		
Peripheral venous catheter	☐ Yes ☐ No ☐ Unk		
Arterial catheter	☐ Yes ☐ No ☐ Unk		
Urinary catheter	☐ Yes ☐ No ☐ Unk		
Other (specify:	☐ Yes ☐ No ☐ Unk		
Other (specify:	☐ Yes ☐ No ☐ Unk		
Other (specify:	☐ Yes ☐ No ☐ Unk		

5. Ventilation/Intubation within 7 days prior to onset date? ☐ Yes ☐ No ☐ Unk

Start Date(s)	Stop Date(s)

6. Blood products received (PRBCs, Platelets, FFP, other) within 7 days prior to onset date?
☐ Yes ☐ No ☐ Unk

Product	Date(s)

F. Nutrition History:

1. Did infant receive breast milk:
   a. Within 7 days prior to onset date? ☐ Yes ☐ No ☐ Unk
   b. Ever? ☐ Yes ☐ No ☐ Unk
2. Did infant receive formula milk?
   a. Within 7 days prior to onset date? ☐ Yes ☐ No ☐ Unk
   b. Ever? ☐ Yes ☐ No ☐ Unk
3. Did infant ever receive thickeners?
   a. In breast milk? ☐ Yes ☐ No ☐ Unk
   b. In formula? ☐ Yes ☐ No ☐ Unk
   c. Strength used? (e.g., 1/2-strength, ¾ strength, honey-thick):_____
4. Did infant receive any supplements?
   a. Within 7 days prior to onset date? ☐ Yes ☐ No ☐ Unk Describe: _____
   b. Ever? ☐ Yes ☐ No ☐ Unk Describe: _____

G. Clinical Information: *Please fill out for case-patients only*

1. Signs and Symptoms within 48 hours prior to or after onset date:

Symptom	Presence	Date of initial finding	Different from "baseline"
Fever (T>37.5°C)	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Low temp (T<36.5)	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Diagnosis of sepsis (Clin Dx)	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Feeding intolerance (Note)	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Lethargy (Note)	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Tachycardia (>180 bpm)	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Tachypnea (>60 rpm)	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Bradycardia (<80 bpm)	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Increase frequency of apnea	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Other: _____	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Other: _____	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Other: _____	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Other: _____	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk

2. Laboratory findings within 48 hours prior to or after onset date:

Abnormal laboratory finding	Presence	Date of Initial finding	Different from "baseline"
Leukocytosis: WBC_____	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Leukopenia: WBC _____	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk

Neutropenia: ANC_____	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Other (specify:)	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk
Other (specify:)	☐ Yes ☐ No ☐ Unk		☐ Yes ☐ No ☐ Unk

3. Microbiology findings: List all positive cultures (clinical and surveillance)
(Date range: Within 7 days prior to onset date until resolution of illness)

☐ No cultures drawn ☐ All cultures negative ☐ Unknown

Date of specimen collection	Source	Organism(s)	# Positive Bottles/Bottles sent (x/y)	Surveillance culture?
				☐ Yes ☐ No ☐ Unk
				☐ Yes ☐ No ☐ Unk
				☐ Yes ☐ No ☐ Unk
				☐ Yes ☐ No ☐ Unk
				☐ Yes ☐ No ☐ Unk
				☐ Yes ☐ No ☐ Unk
				☐ Yes ☐ No ☐ Unk

4. Outcomes:

Outcome	Presence	Date (if applicable)
Ongoing illness	☐ Yes ☐ No ☐ Unk	
Colonization only	☐ Yes ☐ No ☐ Unk	
Death If Yes, attributed to Pseudomonas? If Yes, autopsy performed?	☐ Yes ☐ No ☐ Unk ☐ Yes ☐ No ☐ Unk ☐ Yes ☐ No ☐ Unk	

5. Pathology samples from surgery or autopsy available? ☐ Yes ☐ No ☐ Unknown
Description of pathology results from surgery or autopsy:
_____

_____
_____

H. Bathing/skin care products used within 7 days prior to onset date

Bathing/skin care products used	Brand/Manufacturer	Date(s) of use if known

I. Oral care products used within 7 days prior to onset date

Oral care products used	Brand/Manufacturer	Dates

J. Healthcare personnel exposures within 3 days prior to onset date

Staff	Role	Date(s) of direct patient care if known

K.Location/Environment

1. Location(s) of infant within 7 days prior to onset date (in this hospital)

Unit	Room #	Entrance Date	Exit Date

2. Bed type(s) of infant within 7 days prior to onset date (in this hospital)

Bed Type	Use	Start Date	Stop Date
Giraffe bed/incubator	☐ Yes ☐ No ☐ Unk		
Radiant warmer	☐ Yes ☐ No ☐ Unk		
Open crib or bassinette	☐ Yes ☐ No ☐ Unk		
Other (specify:_____)	☐ Yes ☐ No ☐ Unk		
Other (specify:_____)	☐ Yes ☐ No ☐ Unk		

3. Humidification used within 7 days prior to onset date (in this hospital)? ☐ Yes ☐ No ☐ Unk
Humidity level (max) _____
Source _____

L. POU filter in place for all 7 days prior to positive culture? ☐ Yes ☐ No ☐ Unk

M. Notes/Remarks (Anything potentially relevant about hospital course not included above, including patterns of medication/thickener use, patient course at home, etc.)

_____
_____
_____
_____
_____
_____
_____

N. Medical Chart Abstraction Form Complete?

☐ Yes---- date of completion _____/_____/_____
☐ No

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Health Care Practices Audit Forms

Checklist for Prevention of Central Line Associated Blood Stream Infections

Based on 2011 CDC guideline for prevention of intravascular catheter-associated bloodstream infections: http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf

For Clinicians:

Promptly remove unnecessary central lines

- ☐ Perform daily audits to assess whether each central line is still needed

Follow proper insertion practices

- ☐ Perform hand hygiene before insertion
- ☐ Adhere to aseptic technique
- ☐ Use maximal sterile barrier precautions (i.e., mask, cap, gown, sterile gloves, and sterile full-body drape)
- ☐ Perform skin antisepsis with >0.5% chlorhexidine with alcohol
- ☐ Choose the best site to minimize infections and mechanical complications
  - Avoid femoral site in adult patients
- ☐ Cover the site with sterile gauze or sterile, transparent, semipermeable dressings

Handle and maintain central lines appropriately

- ☐ Comply with hand hygiene requirements
- ☐ Scrub the access port or hub immediately prior to each use with an appropriate antiseptic (e.g., chlorhexidine, povidone iodine, an iodophor, or 70% alcohol)
- ☐ Access catheters only with sterile devices
- ☐ Replace dressings that are wet, soiled, or dislodged
- ☐ Perform dressing changes under aseptic technique using clean or sterile gloves

For Facilities:

- ☐ Empower staff to stop non-emergent insertion if proper procedures are not followed
- ☐ "Bundle" supplies (e.g., in a kit) to ensure items are readily available for use
- ☐ Provide the checklist above to clinicians, to ensure all insertion practices are followed
- ☐ Ensure efficient access to hand hygiene
- ☐ Monitor and provide prompt feedback for adherence to hand hygiene http://www.cdc.gov/handhygiene/Measurement.html
- ☐ Provide recurring education sessions on central line insertion, handling and maintenance

Supplemental strategies for consideration:

- 2% Chlorhexidine bathing
- Antimicrobial/Antiseptic-impregnated catheters
- Chlorhexidine-impregnated dressings

HAND HYGIENE AUDIT TOOL
HAND HYGIENE ADHERENCE DURING HIGH RISK PATIENT CONTACTS

Monitor each clinical area for approximately 30 MINUTES

Hospital _____ Date _____ Start time _____ AM / PM (circle)

Section of Hospital (e.g. ER, adult inpatient, pediatric) _____

If Inpatient Ward, Ward ID _____and number of patients in ward _____

Observer name _____ Location of observer within ward _____

Hand Hygiene Opportunities
Use tick marks to indicate what behavior was observed for each hand hygiene opportunity

Discipline (see below)	No attempt	Attempted without success	Attempted with success	Comments

Discipline: MD=doctor or resident, **RN**=registered nurse, **T**=technician or allied health specialist, **S**=student (medical or nursing)

Duration of observation period: _____ minutes

Total number of patients observed during audit: _____

GUIDE TO HAND HYGIENE OPPORTUNITIES

HIGH RISK FOR TRANSMISSION **Perform hand hygiene before and after each of the following tasks**	
DIRECT PATIENT CONTACT	• **Bathing and mouth care** • **Wound care or dressing changes** • **Repositioning patient** • **Direct patient assessment or care** • **Specimen collection (blood, urine, stool, sputum)** • **Toileting activities** • **Physiotherapy activities** • **Invasive procedures (including, but not limited to, insertion of central or peripheral intravascular devices, lumbar puncture, intubation/ extubation, bladder catheterization, etc)**
MODERATE RISK FOR TRANSMISSION ***** Perform hand hygiene between patients	
INDIRECT PATIENT CONTACT	• Preparing and administering medications • Touching patient equipment at the bedside (eg. Blood pressure cuffs, thermometers) but no patient contact • Transporting patient in a wheelchair or stretcher • After handling patient soiled linens • Before handling food
LOW RISK FOR TRANSMISSION ***** Perform hand hygiene periodically	
ENVIRONMENTAL CONTACT	• Charting or log book entry • Attendance at rounds • Handling stock linens or supplies • After personal toileting

*These contacts/activities are not priority activities to monitor during your audits

Please make note of the following during this session.

	Yes	**No**	**Not applicable**	**Comments**
Posters promoting hand hygiene are visible				
Clinical staff nails are short and clean				
Hand washing areas are clean, operational, and free from clutter				
There is visible and easy access to hand washing sinks or hand sanitizer				
Soap dispensers are available at all hand washing areas				
Paper towels are available at all hand washing stations				

ADDITIONAL COMMENTS / OBSERVATIONS

FORM #:_____

USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE) FOR CONTACT PRECAUTIONS
Infection Prevention and Control Audit

Facility: _____

Patient Unit: _____

Auditor (print): _____

Date: DD_____ MM_____ YYYY_____

Day of Week: S M T W Th F S

Start time: ____:____ End time: _____:_____

Healthcare Worker Category (Circle #):

1 = Physician
2 = Nurse
3 = Healthcare Aide
4 = Social Worker
5 = Spiritual Care
6 = IV Team/ DSM
7 = Physiotherapy
8 = Occupational Therapy
9 = Housekeeping
10 = Patient Transport
11 = Radiology/DI Technician
12 = Respiratory Therapy
13 = Dietary
14 = Speech Language/ Audiology
15 = Rec. Therapy
16 = Pharmacy
17 = Other

Instructions: Select "Y" if activity was observed and completed appropriately; select "N" if activity was observed and not completed appropriately. Select "Not observed" if you were not able to observe the activity.

Bed/Bed Space Location or Number ► _____

Item	Compliance		
Setup			
1. Precaution signage visible before entering the room or bedspace	Y	N	Not observed
2. PPE supplies available immediately outside room or bedspace	Y	N	Not observed
Putting On PPE			
3. Hand hygiene is performed immediately prior to putting on PPE	Y	N	Not observed
4. New single use PPE applied prior to entering room/space	Y	N	Not observed
5. PPE applied in appropriate sequence: A. Gown B. Gloves	Y	N	Not observed
6. Gown worn as indicated by Contact Precautions	Y	N	Not observed
7. Appropriate type of gown is worn (i.e., yellow isolation gown)	Y	N	Not observed
8. Gown securely tied at the neck and then waist	Y	N	Not observed
9. Gloves worn as indicated by Contact Precautions	Y	N	Not observed
Use of PPE			
10. PPE is only worn inside the isolation room/space	Y	N	Not observed
Taking Off PPE			
11. PPE is removed within the isolation room	Y	N	Not observed
12. PPE is removed in a manner to prevent contamination	Y	N	Not observed
13. PPE is removed in appropriate sequence: A. Gloves and gown removed	Y	N	Not observed
B. Hand hygiene performed immediately after removal of PPE	Y	N	Not observed

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Risk Reduction Approach on Burial Practices

Focus Group Guide

Question 1: Tell me about how people feel about Ebola.

[Probe - Are people concerned about Ebola? What is the concern around Ebola? How do you think people are getting Ebola? Probe around burial practices. Are you concerned for Ebola in your family, why or why not?]

Question 2: Before Ebola, when someone died, what happened? Please tell us about the common burial practices.

[Probe – how is the body prepared, what do they wear, color of clothing, how many days, who prayed, different steps regarding tradition and religion (get perspective from both Christians and Muslims), who comes to the house, what is the most important]

Question 3: Ebola is here in Sierra Leone, what have you heard that we should be doing when someone dies? [Probe around 117, safe medical burial]

Question 4: How do you feel about this?

[Probe: Are you worried that someone will hide the body because they do not want safe medical burial.]

Question 5: There have also been messages asking people to stop the burial and attending funerals during this Ebola problem. Why do you think that some people may not follow this advice?

[Probe if reason is due to religious reasons, would it be disrespectful to your community if you did not go to the funeral of someone important?]

Question 6: What would people do to the body after they called 117 and while they wait for the burial team to come?

Question 7: Do you know what happens at the house as part of the safe medical burial? Do you know what happens at the cemetery as part of the safe medical burial? [Probe – Are family members allowed to participate in the safe medical burial. What are some rumors in reference to the medical burial. Probe on their perception.]

Question 8: What will encourage people in this community to stop touch, wash, clean, kiss, wrap the dead body? [Probe around why do you think people are still doing those behaviors.]

Question 9: What can we do to make the safe medical burial processes better?

[Probe: make sure body bags are white, having a religious rep present either at the home or at the cemetery.]

Question 10: Do you have any recommendations for us on making safe medical burial process more acceptable?

[Probe: who can be the people that can help explain the process or ease the process. Probe: Religious leaders blessing? Village chief's blessing? Marking at the grave. Having family members present at the cemetery]

Questions 11: Do you know what happens to the house after the body is removed from the house and buried at the cemetery? Do you know what happens to the other members of the household?

[Probe around quarantine, contact tracing]

[Time permitting, consider ranking exercise]

I. List out various burial practices.
    a. Must Do according to custom
    b. Should Do according to custom
    c. Don't have to do according to custom
II. Whiteboard that list out making burial process more acceptable came up from ranking exercise.
III. Have participants place stickers next to the ones that are acceptable.

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Health-care workers (HCWs) and Ebola Virus Disease (EVD) exposure risk: Reporting form to be completed for EVD cases in HCWs in West Africa

Case ID Number.....

1. PATIENT (HCW) IDENTITY

Last name:..... First Name:..... Second Name:.....
Nickname:.....
Date of birth:...../...../.....(dd/mm/yy) Age (years):..... Sex: ☐ M ☐ F
Village/neighbourhood of residence:...../..... District:.....
GPS coordinates of domicile: Latitude:..... Longitude:.....
Ordinary residence: Head of household (last and first name):.....
Full address (if known):.....
Nationality:..... Ethnic group:.....
Case classification ☐ Suspected ☐ Confirmed

2. PATIENT'S OCCUPATION (tick the appropriate box and provide details if/when necessary)

☐ Doctor ☐ Nurse ☐ Office staff ☐ Laboratory staff ☐ Cleaner ☐ Morgue/burial staff ☐ Midwife
☐ Ambulance driver ☐ Traditional healer ☐ Community health worker ☐ Other (specify):
.....
Health-care facility (HCF) name:.....

Primary work place at the time of infection:

☐ Ebola Treatment Center ☐ Ebola Care Unit ☐ "Transit"/"Holding" center ☐ Public hospital
☐ Outpatient setting ☐ Laboratory ☐ Other (specify):.....
Service: ☐ EVD Suspected Cases Unit ☐ EVD Confirmed Cases Unit ☐ General Care Unit
☐ Maternity ☐ Laboratory ☐ Medicine ☐ Paediatric ☐ Surgery ☐ Emergencies
☐ Blood Transfusion ☐ Administration ☐ Morgue ☐ Other (specify):.....

Additional work place (paid or voluntary) at the time of infection:

☐ Ebola Treatment Center ☐ Ebola Care Unit ☐ "Transit"/"Holding" center ☐ Public hospital
☐ Outpatient setting ☐ Laboratory ☐ Other (specify):.....
Service: ☐ EVD Suspected Cases Unit ☐ EVD Confirmed Cases Unit ☐ General Care Unit
☐ Maternity ☐ Laboratory ☐ Medicine ☐ Paediatric ☐ Surgery ☐ Emergencies
☐ Blood Transfusion ☐ Administration ☐ Morgue ☐ Other (specify):.....
☐ None

Activities that may have led to exposure (tick all that apply):

☐ Provided general patient care (took vital signs, examined patients, moved patients)
☐ Fed patients or administered oral medications
☐ Bathed or cleaned patients ☐ Moved/transported patients
☐ Gave injections ☐ Drew blood ☐ Performed fingerprick ☐ Recapped needle
☐ Discarded sharps ☐ Cleaned needle for re-use
☐ Put in IV ☐ Handled IV line (e.g., gave IV medications) ☐ Handled urinary catheter
☐ Cleaned blood spill ☐ Cleaned patient room or ward ☐ Handled waste
☐ Handled lab specimens ☐ Controlled bleeding ☐ Had contact with contaminated surfaces
☐ Delivered babies

World Health Organization

CDC

Case ID Number.....

☐ Performed invasive procedure ☐ Performed minor surgery ☐ Performed major surgery
☐ Moved dead bodies ☐ Performed autopsy
☐ Cleaned or disinfected latrines
☐ Handled linen or clothes or mattresses (cleaners)
☐ Provided care to sick relatives or significant others
☐ Other: (specify).....

3. CONTACT WITH EVD PATIENT(S):

Has the HCW been in contact* with anyone who had suspected or confirmed EVD in the 3 weeks preceding onset of symptoms? ☐ Yes ☐ No ☐ Don't know

If Yes, was the contact a (*if multiple contacts, indicate 'confirmed' if at least one contact was a confirmed EVD case*):
☐ Suspected EVD case ☐ Confirmed EVD case

If Yes, where (*tick all that apply*):
☐ in an Ebola Treatment Center ☐ Ebola Care Unit ☐ in another HCF
☐ in a private clinic/cabinet ☐ at home ☐ in the community

If Yes, specify relationship with HCW (*tick all that apply*):
☐ Patient ☐ Other HCW ☐ Household member
☐ Other friend or relative ☐ None

If other HCW included in previous response, did the contact occur:
☐ At work, in a patient care area
☐ At work, in a non-patient care area (break room, office, nursing station, etc)
☐ Outside work

Did the HCW attend the funeral of someone who might have died of Ebola in the 3 weeks preceding the onset of symptoms? ☐ Yes ☐ No

If Yes, did the HCW participate in the preparation of burials involving touching the dead body, with no adequate personal protective equipment (PPE)**? ☐ Yes ☐ No

If Yes, did the HCW provide care to any suspected Ebola patients in a private home (not in a HCF)?
☐ Yes ☐ No

4. MOST LIKELY EXPOSURE TO EVD

Did the HCW describe any single exposure situation that most likely led to infection? ☐ Yes ☐ No ☐ Don't know

If Yes, skip the next three questions and go to section 5
If No, specify the date:...../...../.....(dd/mm/yy)

Setting where suspected exposure occurred:
☐ Ebola Treatment Center ☐ Ebola Care Unit ☐ "Transit"/"Holding" center ☐ Public hospital
☐ Outpatient setting ☐ Laboratory ☐ Other type of HCF (specify):.....
☐ Home ☐ Other community setting (specify):.....

Mode of exposure:
☐ Needle stick ☐ Scalpel cut ☐ Blood/body fluid splash on intact skin ☐ Blood/body fluid splash on non-intact skin
☐ Blood/body fluid splash on eye ☐ Blood/body fluid splash on mouth/lips ☐ Other (specify).....

Contaminant:
☐ Blood ☐ Any body fluid with visible blood ☐ Vomit or saliva ☐ Faeces ☐ Urine
☐ Internal body fluids (circle which one [s]): cerebrospinal, synovial, pleural, amniotic, pericardial, peritoneal
☐ Vaginal secretions ☐ Seminal fluid ☐ Other (specify):.....

World Health Organization

Case ID Number.....

5. INFECTION PREVENTION AND CONTROL ASPECTS OF PRIMARY WORK PLACE

Use of PPE and Standard Precautions:

At time of exposure, was any PPE used? ☐ Yes ☐ No ☐ Don't know

If Yes, which ones (*tick all that apply*): ☐ Single gloves ☐ Double gloves ☐ Disposable gown
☐ Coverall (Tyvek-like) ☐ Face shield ☐ Face mask ☐ N-95 respirator or above
☐ Goggles ☐ Waterproof apron ☐ Closed resistant shoes ☐ Shoe covers ☐ Gum boots
☐ Cap ☐ Hood ☐ Leg covers ☐ Other (specify):.....

Did the HCW apply duct tape to secure your PPE ☐ Yes ☐ No ☐ Don't know

Were hand hygiene products available at the time of exposure ☐ Yes ☐ No ☐ Don't know

If Yes, which ones (*tick all that apply*): ☐ Running (tap) water ☐ Chlorinated water from reservoir
☐ Soap ☐ Disposable towels ☐ Alcohol antiseptic

Was hand hygiene performed appropriately*?** ☐ Yes ☐ No ☐ Don't know

At time of exposure, were safety boxes available? ☐ Yes ☐ No ☐ Don't know

On average, how many hours did you work while wearing PPE in the isolation area?**.....

Have you been trained on infection prevention and control in the context of the Ebola outbreak? ☐ Yes ☐ No

Which organization led this training?

☐ National Government ☐ WHO ☐ CDC ☐ MSF ☐ UNMEER
☐ Other (specify):..... ☐ Don't know

* Contact defined as the HCW touching, without proper personal protective equipment (PPE), a suspect or confirmed EVD patient or their bodily fluids.

** PPE= gloves, impermeable gown or coverall, impermeable head cover with neck protection, rubber boots, face mask and face shield or goggles.

*** Appropriate hand hygiene indications: before donning gloves and wearing PPE; before any clean/aseptic procedures; after any exposure risk or actual exposure to the patient's blood and body fluids; after touching (even potentially) contaminated surfaces/items/equipment; after removal of PPE, upon leaving the care area.

Additional details of exposure or comments:.....

.....

.....

.....

.....

.....

.....

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Rapid Anthropological Assessment
Topic Guide for Community Leader Focus Group Discussion

RAPID ANTHROPOLOGICAL ASSESSMENT
TOPIC GUIDE FOR COMMUNITY LEADER FGD

Community Knowledge about Ebola and Care-Seeking Behaviors

1. What are people in this community saying about Ebola? What are some of their concerns?

2. What do people do to prevent themselves or family members from getting Ebola?

3. What do people usually do if they think they or a family member has Ebola?

4. If a family member becomes sick with Ebola, what happens to people who live in the same house?

4.1 What happens to the friends and neighbours they know?

5. What are some of the reasons people might not want to seek treatment if they think they or a family member has Ebola?

6. Does this community have an Ebola Task Force? If yes, what is its role?

6.1 Which groups of people are on the Task Force?

Ebola-Related Services in the Community

7. What is the government doing to help people who get sick from Ebola?

8. What are other organizations doing to help?

9. What are the names of the ETUs that you know? What are people saying about the different ETUs?

Community-Based Deaths

10. What happens if someone in the community dies at home? What do family members do?

10.1 What do community members do?

11. What do family members do if a child dies from Ebola at home? An adult? An elderly person?

11.1 Do family members use a funeral home for the death of a child? For an adult?

12. If someone dies at home, how long do people usually keep the body at home?

12.1 Is there any stigma to keeping the body at home?

13. Since this Ebola business started, has anyone died in this community? If yes, did they die at home or somewhere else?

13.1 What happened to the body?

14. Have you ever heard that sometimes people bury the body secretly? If yes, ask:

14.1 Why do they do bury secretly and who conducts the secret burial?
14.2 How much do secret burials cost?
14.3 Have there been any secret burials in this community?

15. Which bodies are people more likely to bury in secret? Why?

16. What does the government say people should do if someone dies at home? Are people supposed to call anyone? If so, who?

16.1 Do people follow the government's advice? Why or why not? [If not mentioned, probe about cremation policy]

FINAL COMMENTS OR SUGGESTIONS

17. What do you think the government should do about Ebola?

18. What do you think the government should do when people die at home?

19. Is there anything else about Ebola in this community or in Liberia that you would like to mention or think we should know? Is there anything you think the government should know?

COMMUNITY DEMOGRAPHICS

20. How many people live in this community?

21. How is this community organized in terms of leadership? What are the different leadership positions and responsibilities? (E.g. Community chairperson, governor, other community group leader, community members, etc.)

22. How are community leaders selected?

23. What different types of social groups or organizations are there in the community (e.g. women's groups, youth groups, etc.)?

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Rapid Anthropological Assessment
Topic Guide for Community Member Focus Group Discussion

RAPID ANTHROPOLOGICAL ASSESSMENT
TOPIC GUIDE FOR COMMUNITY LEADER FGD

Community Knowledge about Ebola and Care-Seeking Behaviors

1. What are people in this community saying about Ebola? What are some of their concerns?

2. What do people do to prevent themselves or family members from getting Ebola?

3. What do people usually do if they think they or a family member has Ebola?

4. If a family member becomes sick with Ebola, what happens to people who live in the same house?

4.1 What happens to the friends and neighbours they know?

5. What are some of the reasons people might not want to seek treatment if they think they or a family member has Ebola?

6. Does this community have an Ebola Task Force? If yes, what is its role?

6.1 Which groups of people are on the Task Force?

Ebola-Related Services in the Community

7. What is the government doing to help people who get sick from Ebola?

8. What are other organizations doing to help?

9. What are the names of the ETUs that you know? What are people saying about the different ETUs?

Community-Based Deaths

10. What happens if someone in the community dies at home? What do family members do?

10.1 What do community members do?

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14. Have you ever heard that sometimes people bury the body secretly? If yes, ask:

14.1 Why do they do bury secretly and who conducts the secret burial?
14.2 How much do secret burials cost?
14.3 Have there been any secret burials in this community?

15. Which bodies are people more likely to bury in secret? Why?

16. What does the government say people should do if someone dies at home? Are people supposed to call anyone? If so, who?

16.1 Do people follow the government's advice? Why or why not? [If not mentioned, probe about cremation policy]

Final Comments or Suggestions

17. What do you think the government should do about Ebola?

18. What do you think the government should do when people die at home?

19. Is there anything else about Ebola in this community or in Liberia that you would like to mention or think we should know? Is there anything you think the government should know?

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Rapid Anthropological Assessment
Topic Guide for Contact Tracer Focus Group Discussion

RAPID ANTHROPOLOGICAL ASSESSMENT
TOPIC GUIDE FOR CONTACT TRACER FGD

1. What are people in the communities you visit saying about Ebola? What are some of their concerns?

2. What are the job responsibilities of a contact tracer?

3. How do you know which people are contacts?

4. How do you know which homes to visit?

5. What do you do once you arrive at a home?

6. What kind of information do you collect?

7. Which forms do you fill out?

8. What do you do if the people refuse to provide the information?

9. What do you do if the contacts you are supposed to see are not at home?

10. What happens with the information you collect from the contacts you visit?

11. What Ebola safety precautions do you take while you are working?

Challenges of the Job

12. What are the biggest challenges of your job?

13. What was the reason you decided to work as a contact tracer?

14. How were you recruited?

15. How long have you had this job?

16. What type of training have you received for this job?

17. Who provided the training and how long did the training last?

18. What kinds of things did you learn?

19. Have you received any refresher training? If so, how many times?

20. What kinds of things did you learn at the refresher training?

Final Comments or Suggestions

21. What do you think the government should do about Ebola?

22. What do you think the government should do when people die at home?

23. Is there anything else about your job or Ebola that you would like to mention or think we should know? Is there anything you think the government should know?

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Rapid Anthropological Assessment
Topic Guide for Contact Tracer Supervisor Key Informant Interview

RAPID ANTHROPOLOGICAL ASSESSMENT
TOPIC GUIDE FOR CONTACT TRACER SUPERVISOR KII

Community Knowledge about Ebola and Care-Seeking Behaviors

1. What are people in the communities you visit saying about Ebola? What are some of their concerns?

2. What are your job responsibilities of a contact tracer supervisor?

3. How is your team notified about which contacts to follow?

4. How do they know which homes to visit?

5. What are contact tracers supposed to do once they arrive at a home?

6. What kind of information do they collect?

7. What are they supposed to do if the people they are supposed to see are not at home?

8. What do you do with the information the contact tracers collect?

Challenges of the Job

9. What are the biggest challenges of your job?

10. What was the reason you decided to work as contact tracer supervisor?

11. How long have you been a supervisor?

12. How were you recruited?

13. What type of training did you receive?

14. Who provided the training and how long did the training last?

15. Have you received any refresher training? If yes, when?

16. What kinds of things did you learn?

Final Comments or Suggestions

17. What do you think the government should do about Ebola?

18. What do you think the government should do when people die at home?

19. Is there anything else about Ebola in this community that you think I should know? Is there anything you think the government should know?

Demographics

20. How old are you?

21. What is the last grade you completed in school?

22. Which languages do you speak?

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Ebola Virus Disease Contact Tracing Form

State/Local ID: CDC ID:

I. Interview Information

Date of interview: MM / DD / YYYY

Interviewer:

Interviewer Name (Last, First): _____

State/Local Health Department: _____

Business Address: _____

City: _____ State: _____ Zip: _____County: _____

Phone number: _____ Email address: _____

Contact:

Who is providing information for this form?

ÿ Contact

ÿ Other, specify person (Last, First): _____

Relationship to contact: _____

Reason contact unable to provide information: ÿ Contact is a minor ÿ Other _____

Contact primary language: _____

Was this form administered via a translator? □ Yes □ No

II. Ebola Case Information (Case associated with Contact)

At the time of this report, is the patient? □ Confirmed □ Probable □ Unknown

Date of illness onset of patient: MM / DD / YYYY

Notes:

III. Contact Information

Last Name: _____ First Name: _____

Home Street Address: _____ Apt. # _____

City: _____ County: _____ State: _____ Zip: _____

Time at current residence: _____

Previous address *(if less than 1 month at current residence):*

Home Street Address: _____ Apt. # _____

City: _____County: _____ State: _____ Zip: _____

Country:_____

Phone number: _____ Email address: _____

Other Phone number or contact information:: _____

IV. Contact Demographics

Date of birth: MM **/** DD **/** YYYY **Age:**

Sex: ÿ Male ÿ Female

What is your occupation? _____ ÿ ***If HCW that provided care to Ebola patient or worker (in any capacity including janitorial, lab, medical waste, food services, etc.)at a healthcare facility that treated Ebola patient, skip to Section VII now***

Place of work and address:

_____

_____

Do you have any pets in your household?: ÿ Yes Give species and number_____ ÿ No

NOTES:

V. Exposure History

*Question assesses LOW exposure; †Question assesses HIGH exposure; ‡Question assesses casual contact or NO KNOWN exposure; Note: direct contact requires contact with skin and or mucous membranes.

1) What is your relationship to the patient?

☐ Partner/spouse ☐Family member ☐Co-worker

☐[illegible] ☐[illegible] same healthcare facility/care area as Ebola patient

☐[illegible] ☐[illegible]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX_____

2) *Do you live in the same house as the patient? ☐[illegible]

3) Did you have any contact with the patient while he/she was ill? ☐ Yes ☐[illegible]

If yes, please describe and provide dates of first and last contact (include description of any PPE used):

_____

_____

4) †Did you have any contact with blood or body fluids from the patient while he/she was ill (including contaminated objects or surfaces such as bedding or clothing)? ☐Yes *(Skip to Q5)* ☐No ☐[illegible]

If yes, what body fluids were you in contact with? (check all that apply)

☐ Blood ☐Feces ☐Vomit ☐Urine ☐Sweat

☐ Tears ☐Respiratory secretions

☐[illegible]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX[illegible]

Last date of contact: MM / DD / YYYY **(Skip to Section VI)**

5) *Were you within approximately 3 feet of the patient or within his/her room or care area for a prolonged period of time (at least one hour)? ☐Yes ☐No ☐Unsure

If yes, date of last contact: MM / DD / YYYY

6) *Did you have any direct contact with the patient (e.g. shaking hands) no matter how brief?

☐[illegible] Date of last contact: MM / DD / YYYY **(Skip to Section VI)**

☐No ☐Unsure

7) ‡Did you have any casual contact with the patient (meaning a brief interaction, such as walking by him/her or being in the same room for a very short period of time) in which you did not directly touch him/her?

☐Yes ☐No ☐Unsure

If yes, date of last contact: MM / DD / YYYY

VI. Activities During Period Of Exposure

Did you participate in any of the following activities with the patient while he/she was ill?

Caregiving

Did you take care of the patient when he/she was sick (e.g. bathe, feed, help to bathroom)? ÿYes ÿNo ÿUnsure

Did you do house cleaning or provide indirect care for the patient (e.g. wash clothes or bedding, wash dishes)? ÿYes ÿNo ÿUnsure

Sharing Meals

Did you eat meals with the patient? ÿYes ÿNo ÿUnsure

Did you share utensils or a cup with the patient? ÿYes ÿNo ÿUnsure

Other close contact

Did you use the same bathroom as the patient? ÿYes ÿNo ÿUnsure

Did you sleep in the same room as the patient? ÿYes ÿNo ÿUnsure

Did you sleep in the same bed as the patient? ÿYes ÿNo ÿUnsure

Did you hug the patient? ÿYes ÿNo ÿUnsure

Did you kiss the patient? ÿYes ÿNo ÿUnsure

Transportation

Did you share any transport with the patient (car, bus, plane, taxi, etc.)? ÿYes ÿNo ÿUnsure

If yes, give for *all* shared transport: Conveyance _____ Dates of travel: _____

Name of airline and flight number: _____

Origin: _____ Destination: _____

Any transit points: _____

Notes:

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

Ebola Exposure Assessment Questionnaire for Airline Passengers

Directions: Please fax completed form to Ebola Airline Investigation at fax # 404.718.2158 after both initial interview and completion of final disposition.

*****Note: If contact is determined to have a fever ≥100.4° F, immediately call EOC at 770.488.7100.**

Date of initial interview: _____/_____/_____Interviewed by: _____

1. Last Name:_____ First Name:_____ Age:_____

   Sex: ____ Country of Birth: _____ Country of Residence: _____

   Travel Plans through insert date: _____

   Street Address: _____ State:_____

   Phone numbers- Home: _____ Cell:_____ Work:_____

   Circle flight(s) interviewee was on: [Complete flight information]

   [Complete second flight information]

Assigned seat number: _____ Did interviewee move to a different seat? ☐ Yes ☐ No
If yes, which seat did interviewee move to? _____ Document time in each seat:

_____

2. Did interviewee have any interactions with sick passengers from this flight(s)? ☐ Yes ☐ No

   If yes, describe this event including location, degree of contact (talking with or touching) and length of time:_____

3. Did interviewee have direct contact with body fluids of any passengers during the flight(s) circled above?

   ☐ Yes ☐ No (If no, skip to question 4)

   If yes, describe the contact including location of the body fluid and any other individuals involved:

   _____

   If yes, which body fluids did interviewee come into contact with? (Check all that apply)

   ☐ Tears ☐ Saliva ☐ Respiratory secretions (cough and sneeze droplets)

   ☐ Vomit ☐ Urine ☐ Blood ☐ Stool ☐ Sweat

   If yes, did these fluids come in contact with the interviewee's:

   ☐ Intact skin

   ☐ Broken skin (fresh cut or scratch which bled within 24 hours before the contact; burn or abrasion that had not dried)

   ☐ Mucous membrane contact (eyes, nose or mouth)

   ☐ Other (Specify): _____

4. Were there any incidents during or after the flight(s) that the interviewee can recall when other individuals were in contact with a person's blood and/or body fluids?

   ☐ Yes ☐ No

   If yes, please describe situation and location in the plane and/or airport:

   _____

5. Please check all symptoms interviewee has had since flight:

☐ Fever ≥100.4° F	☐ Sore throat	☐ Body aches/muscle pain	☐ Headache
☐ Abdominal pain	☐ Vomiting	☐ Diarrhea	☐ Weakness
☐ Rash	☐ Hiccups	☐ Unusual bleeding (e.g. from gums, eyes or nose)	

6. Has interviewee travelled in any of the following countries within the last 21 days (check all that apply)?

☐ Sierra Leone ☐ Guinea ☐ Liberia ☐ Other

If any of the above countries are selected, please notify CDC by calling EOC. Contact will need to complete additional brief interview with CDC SME involving in-country exposure risk.

Classification of interviewee risk (Consult the CDC to classify each contact after interview. Refer to http://www.cdc.gov/vhf/ebola/hcp/case-definition.html for additional information):

☐ High Risk: The index case's body fluids came in contact with the interviewee's bare skin (intact or broken) or mucous membranes (eyes, mouth, nose).

☐ Some Risk: Interviewee had close contact* with the index case but not body fluids; or was only exposed on protected areas of the body (e.g. on hands while wearing gloves).

☐ No Known Risk**: Interviewee did not have any *some risk* or *high risk* exposures listed above.

Follow-up Actions:

☐ Ebola information distributed

☐ Fever watch: For all contacts regardless of classification of risk, provide fever watch form that should be reviewed by health department at least weekly.

☐ Referred for medical evaluation due to presence of symptoms. If yes,

Where was (s)he referred? _____

What was the outcome? _____

☐ Declined medical evaluation after it was recommended

Was interviewee placed under conditional release? ☐ Yes ☐ No

Was interviewee placed under state issued quarantine order? ☐ Yes ☐ No

Final Disposition:

Was interviewee contacted again after [Fill in the date of the last day of the incubation period]?

☐ Yes, Date of second interview: _____/_____/_____ ☐ No

If yes, did interviewee develop any symptoms of Ebola between the time of flight and [Fill in date]?

☐ Yes ☐ No

If yes, please describe the symptoms, timing, and outcome of medical evaluation below:

_____

Evaluating healthcare provider name/phone number: _____/(____)_____

* Close contact is defined as a) being within approximately 3 feet (1 meter) or within the room or care area for a prolonged period of time (e.g., healthcare personnel, household members) while not wearing recommended personal protective equipment (i.e., droplet and contact precautions–see Infection Prevention and Control Recommendations); or b) having direct brief contact (e.g., shaking hands) with an EVD case while not wearing recommended personal protective equipment (i.e., droplet and contact precautions–see Infection Prevention and Control Recommendations). At this time, brief interactions, such as walking by a person or moving through a hospital, do not constitute close contact.

**No known risk may include passengers who were seated within 3 feet of the passenger for only a short amount of time.

Bridal Store Visitor Questionnaire

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

Number _____ Last Name _____ First Name _____

This is _____ with Summit Count Public Health; I am returning your call. We obtained clarification from the Centers for Disease Control and Prevention (CDC) and would like to pass along the information to you. **(Instructions to interviewers are in bold.)**

Did you go to the store, Coming Attractions Bridal and Formal (1220 E Tallmadge Ave, Akron, OH 44310) on Saturday, October 11?

☐ Yes
☐ No

If no, only people who were at the store on October 11 between 12:00 and 3:30 are at risk. Proceed with fact sheet.

Were you in Coming Attractions between 12 (noon) and 3:30 PM?

☐ Yes
☐ No

If no, only people who were at the store on October 11 between 12:00 and 3:30 are at risk. Proceed with fact sheet.

How long were you in the store?

What were you doing?

If they were in store: refer to chart below to determine risk level. Circle level. Read instructions.

Less Than One Hour – Very Low to No Risk	One Hour or More – Low Risk
• Self monitor: Take temperature twice a day, write it down. • Call Dr. Margo Erme at 330-283-6380 or Anne Morse, Communicable Disease Nurse at 330-780-5690, if temperature or symptoms (Fever>100.4, headache, join or muscle aches, nausea, vomiting, abdominal/stomach cramps, rash, unusual bleeding)	• Active Monitoring: twice daily monitoring, including phone follow up once daily. • Schedule visit to explain follow-up, distribute materials • Visit date/Time _____ • Best time to call morning or evening **(Circle one)** • Best Number _____ • Alternate Number _____

Interviewer Name _____ Date of Interview _____ Time of Interview _____

Daily Contact Symptom Follow-up Log

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

VII. Contact Symptom Follow-Up Diary				
1 day after last exposu MM / DD / YYYY	**2 days after last expos** MM / DD / YYY	**3 days after last exposure** MM / DD / YYYY	**4 days after last exposure** MM / DD / YYYY	**5 days after last exposure** MM / DD / YYYY
□ No symptoms □ Fever _____°F □ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain □ Diarrhea ____times/ □ Vomiting □ Unexplained hemorrh □ Other _____	□ No symptoms □ Fever _____°F □ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain □ Diarrhea ____times/ □ Vomiting □ Unexplained hemorrh □ Other _____	□ No symptoms □ Fever _____°F □ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain □ Diarrhea ____times/day □ Vomiting □ Unexplained hemorrhage □ Other _____	□ No symptoms □ Fever _____°F □ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain □ Diarrhea ____times □ Vomiting □ Unexplained hemorrhage □ Other _____	□ No symptoms □ Fever _____°F □ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain □ Diarrhea ____times/day □ Vomiting □ Unexplained hemorrhage □ Other _____
6 days after last expos MM / DD / YYYY	**7 days after last expos** MM / DD / YYYY	**8 days after last exposure** MM / DD / YYYY	**9 days after last exposure** MM / DD / YYYY	**10 days after last exposure** MM / DD / YYYY
□ No symptoms □ Fever _____°F □ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain □ Diarrhea ____times/ □ Vomiting □ Unexplained hemorrh □ Other _____	□ No symptoms □ Fever _____°F □ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain □ Diarrhea ____times/ □ Vomiting □ Unexplained hemorrh □ Other _____	□ No symptoms □ Fever _____°F □ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain □ Diarrhea ____times/day □ Vomiting □ Unexplained hemorrhage □ Other _____	□ No symptoms □ Fever _____°F □ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain □ Diarrhea ____times □ Vomiting □ Unexplained hemorrhage □ Other _____	□ No symptoms □ Fever _____°F □ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain □ Diarrhea ____times/day □ Vomiting □ Unexplained hemorrhage □ Other _____

11 days after last exposure MM / DD / YYYY	**12 days after last exposure** MM / DD / YYYY	**13 days after last exposure** MM / DD / YYYY	**14 days after last exposure** MM / DD / YYYY	**15 days after last exposure** MM / DD / YYYY
☐ No symptoms ☐ Fever ________°F ☐ Chills ☐ Weakness ☐ Headache ☐ Muscle Aches ☐ Abdominal Pain ☐ Diarrhea ____times/ ☐ Vomiting ☐ Unexplained hemorrha ☐ Other ____________	☐ No symptoms ☐ Fever ________°F ☐ Chills ☐ Weakness ☐ Headache ☐ Muscle Aches ☐ Abdominal Pain ☐ Diarrhea ____times/ ☐ Vomiting ☐ Unexplained hemorrh ☐ Other ____________	☐ No symptoms ☐ Fever ________°F ☐ Chills ☐ Weakness ☐ Headache ☐ Muscle Aches ☐ Abdominal Pain ☐ Diarrhea ____times/day ☐ Vomiting ☐ Unexplained hemorrhage ☐ Other ________________	☐ No symptoms ☐ Fever ________°F ☐ Chills ☐ Weakness ☐ Headache ☐ Muscle Aches ☐ Abdominal Pain ☐ Diarrhea ____times ☐ Vomiting ☐ Unexplained hemorrhage ☐ Other ____________	☐ No symptoms ☐ Fever ________°F ☐ Chills ☐ Weakness ☐ Headache ☐ Muscle Aches ☐ Abdominal Pain ☐ Diarrhea ____times/day ☐ Vomiting ☐ Unexplained hemorrhage ☐ Other ________________

16 days after last exposure MM / DD / YYYY	**17 days after last exposure** MM / DD / YYYY	**18 days after last exposure** MM / DD / YYYY	**19 days after last exposure** MM / DD / YYYY	**20 days after last exposure** MM / DD / YYYY
☐ No symptoms ☐ Fever ________°F ☐ Chills ☐ Weakness ☐ Headache ☐ Muscle Aches ☐ Abdominal Pain ☐ Diarrhea ____times/day ☐ Vomiting ☐ Unexplained hemorrhage ☐ Other ________________	☐ No symptoms ☐ Fever ________°F ☐ Chills ☐ Weakness ☐ Headache ☐ Muscle Aches ☐ Abdominal Pain ☐ Diarrhea ____times/day ☐ Vomiting ☐ Unexplained hemorrhage ☐ Other ________________	☐ No symptoms ☐ Fever ________°F ☐ Chills ☐ Weakness ☐ Headache ☐ Muscle Aches ☐ Abdominal Pain ☐ Diarrhea ____times/day ☐ Vomiting ☐ Unexplained hemorrhage ☐ Other ________________	☐ No symptoms ☐ Fever ________°F ☐ Chills ☐ Weakness ☐ Headache ☐ Muscle Aches ☐ Abdominal Pain ☐ Diarrhea ____times/day ☐ Vomiting ☐ Unexplained hemorrhage ☐ Other ________________	☐ No symptoms ☐ Fever ________°F ☐ Chills ☐ Weakness ☐ Headache ☐ Muscle Aches ☐ Abdominal Pain ☐ Diarrhea ____times/day ☐ Vomiting ☐ Unexplained hemorrhage ☐ Other ________________

21 days after last exposure
MM / DD / YYYY

□ No symptoms
□ Fever _____°F
□ Chills
□ Weakness
□ Headache
□ Muscle Aches
□ Abdominal Pain
□ Diarrhea ____times/day
□ Vomiting
□ Unexplained hemorrhage
□ Other _____

NOTES:

Domestic Animal Questionnaire for Contacts under Active Monitoring

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

Name_____

Address_____

Phone Number_____

Please provide the following information on your pet:

- Species (i.e. dog, cat)_____
- Name_____
- Breed_____
- Sex and Spay/Neuter Status_____
- Age_____
- Markings(provide a photo if possible)_____
- Other identifying characteristics_____
- Vaccination history- esp. Rabies _____
- Medical Issues/ Need for Medication _____
- Name/ Phone Number of Veterinarian _____
- Microchip Number- If Applicable_____
- Contact Information/ Address for an Alternate Decision Maker/ Location

  _____

Form Approved
OMB No. 0920-1011
Exp Date: 3/31/2017

Ebola Virus Disease Contact Questionnaire

Interviewee name: _____ DRAFT 09/30/2014 State ID No.: _____

Ebola Virus Disease Case Contact Questionnaire

The purpose of this questionnaire is to assess the type of contact you may have had with a confirmed or probable case of Ebola Virus Disease (EVD). The information obtained from these questions will determine your risk of exposure to EVD -- high risk, low risk, or no known risk. Depending upon your risk exposure category you may be required to monitor yourself for any signs or symptoms of EVD for 21 days following your last date of contact. A form should be completed per confirmed or probable case of EVD with whom you had contact.

Important terms:

Symptoms	Fever (>101.5°F or 38.6°C); Severe headache; Muscle pain; Weakness; Diarrhea; Vomiting; Abdominal pain; Unexplained hemorrhage (bleeding or bruising).
Close contact	A.) Being within ~3 feet (1 meter) of an EVD patient or within the patient's room or care area for a prolonged period of time (e.g., household member, healthcare personnel) while not wearing personal protective equipment, OR B.) Having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended personal protective equipment. NOTE: Brief interactions, such as walking by a person, do NOT constitute close contact.
Personal Protective Equipment	Protective equipment used for standard, contact, and droplet precautions (e.g., gloves, impermeable gown, eye protection, facemask, etc.)

Interviewer Information:

Date of interview: _____ *(M, D, Yr)*

Interviewer: _____

Affiliation: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone *(cell)*: _____ Telephone *(office)*: _____

Email: _____

Interviewee name: _____ State ID No.: _____

EVD Patient Information:

EVD patient name: _____ State ID No.: _____

Symptom onset date: _____ *(M, D, Yr)* Date of death *(if applicable)*: _____ *(M, D, Yr)*

1. What is your relationship to the patient?

- ☐ Family member
- ☐ Co-worker
- ☐ Friend
- ☐ Classmate
- ☐ Patient *(healthcare setting)*
- ☐ Other, specify: _____

2. Was the patient alive or deceased during your contact?

- ☐ Alive
- ☐ Alive, then deceased
- ☐ Deceased

3. Did you have close contact with the patient while they had symptoms?

(see important terms on page 1 for definition of close contact and symptoms of EVD)

- ☐ No *(If no, then see 'No Known Risk' under risk classification on page x)*
- ☐ Yes

4. What was the LAST date of close contact with the patient? _____ *(M, D, Yr)*

5. What was the nature of your contact with the patient while they were symptomatic? *(check all that apply)*

Household

- ☐ Live in same household
- ☐ Attend to the patient's direct care in a household setting *(bathe, feed, help to bathroom, et.c)*
- ☐ Attend to the patient's indirect care in a household setting *(launder linens, wash dishes, clean patient's room)*
- ☐ Visit patient's household *(no direct or indirect patient contact or care)*

Healthcare

- ☐ Attend to the patient's direct care in a hospital / outpatient setting *(physician, nurse, EMS, etc.)*
- ☐ Perform laboratory services *(phlebotomy, other sample collection, laboratory testing, etc.)*
- ☐ Perform custodial services *(launder linens, disinfect equipment, clean patient's room)*
- ☐ Attend to the patient's food service needs *(deliver food tray to room, pick up food tray, etc.)*
- ☐ Perform an autopsy, surgery, or other medical examination

Funeral

- ☐ Prepare, or help prepare, the body for funeral/burial services *(e.g., wash, embalm, or dress the body)*
- ☐ Have other direct contact with the body during funeral/burial services
- ☐ Only attend funeral/burial services *(no direct contact with the body)*

(question continued on next page)

Interviewee name: _____ State ID No.: _____

5. What was the nature of your contact with the patient while they were symptomatic? *(continued)*

Other contact

- ☐ Share transportation *(plane, taxi, bus, etc.)* Length of time *(hours)*: _____
- ☐ In the same daycare class
- ☐ Casual contact as in an office or school setting
- ☐ Other, specify: _____

6. Did you have contact with blood or other body fluid(s) from the patient while they had symptoms?

- ☐ No
- ☐ Yes

7. What body fluid(s) did you contact? *(check all that apply)*

☐ Blood	☐ Saliva	☐ Tears	☐ Vaginal fluid
☐ Vomitus	☐ Sweat	☐ Breast milk	☐ Respiratory/Nasal secretions
☐ Stool	☐ Urine	☐ Semen	☐ Cerebral spinal fluid (CSF)

☐ Other, specify: _____

8. Was your contact with body fluids the result of an occupational exposure?

- ☐ No
- ☐ Yes *If yes, facility name:* _____

9. What was your type of contact with the body fluids? *(check all that apply)*

- ☐ No direct contact due to appropriate PPE
- ☐ Contact with your intact skin
- ☐ Contact with your broken skin *(fresh cut, burn, abrasion that had not dried)*
- ☐ Contact with your mucous membranes *(eyes, nose, mouth, etc.)*
- ☐ Other, specify: _____

10. What personal protective equipment was used? *(check all that apply)*

☐ Gloves	☐ Double gloves	☐ Glasses/goggles
☐ Tyvek suit	☐ Face shield	☐ Facemask
☐ Leg covers	☐ Shoe covers	☐ Surgical scrub suit
☐ Surgical mask	☐ Gown *(fluid resistant and impermeable)*	

11. Did you have any other contact with the patient not previously mentioned?

Interviewee name: _____ State ID No.: _____

Risk Classification:

☐ High Risk

- Direct exposure to body fluids of the EVD patient
- Direct care of a confirmed or suspected EVD patient without PPE
- Laboratory worker processing body fluids without appropriate laboratory biosafety precautions
- Participation in funeral/burial rites or body preparation of the EVD patient without appropriate PPE

☐ Low Risk

- No high risk exposures identified
- Direct brief contact with an EVD patient *(e.g., shaking hands)*
- Close contact with an EVD patient *(within 3 feet (1 meter) for a prolonged period)*

☐ No known risk

- No high or low risk exposures identified
- No contact with the EVD patient

Follow-up Actions:

☐ No further follow-up required *(no known risk or last exposure >21 days).*

☐ Fever monitoring recommended *(high and low risk only)*

Last exposure date: _____ *(M, D, Yr)*

Last day of monitoring *(day 22)*: _____ *(M, D, Yr)*

Who will conduct the follow-up for fever and symptom monitoring?

Contact: _____ Telephone: _____

Affiliation: _____

(hand out paperwork for monitoring - fever / symptom log and guidance document if contact develops symptoms)

☐ Fever monitoring recommended but respondent is refusing follow-up

☐ Respondent has had a fever or other symptom(s) of EV since having contact with the patient

First symptom: _____ Onset date: _____ *(M, D, Yr)*

Temperature: _____ °F Fever onset date: _____ *(M, D, Yr)*

Where will the respondent be evaluated? _____

(if the respondent is symptomatic complete a case investigation form)

Respondent Information:

Respondent: _____

Date of birth: _____ *(M, D, Yr)* Sex: ☐ Female ☐ Male

Address: _____

City: _____ State: _____ Zip code: _____

Telephone *(cell)*: _____ Telephone *(home)*: _____ Telephone *(work)*: _____

Email: _____

Form Approved
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Ebola Virus Disease Contact Questionnaire (Revised)

Ebola Virus Disease Contact Questionnaire (Revised)

Date of interview:

EVD patient name:

EVD patient symptom onset date:

EVD patient date of death, if applicable:

Contact Name:

Age:

Address:

Telephone Number:

Occupation/Job of Contact:

Workplace Name and Address:

Workplace Telephone Number:

Emergency Contact # 1:

Emergency Contact # 2:

1. What is your relationship to the case? _____

If the interviewee is not the contact, please indicate the relationship to the contact (i.e. interviewing the parent of a child)

- ☐Family member of contact
- ☐Co-worker/classmate
- ☐Friend
- ☐Housemate/roommate
- ☐Other, specify

2. What was your last date of contact with the case (mm/dd/yyyy)? _____

Community/Household Contacts

3. Did you visit the household while the case had symptoms? ☐Yes ☐No

4. Did you have contact with the case outside of his/her home? ☐Yes ☐ No

If yes, what was the nature of your contact with the case while they were symptomatic?

- ☐Share transportation (plane, taxi bus, etc.)
- ☐Casual contact (i.e. school, office, bank)
- ☐Other, specify:_____

5. Did the case come in contact with any people while you were with them? If so, please provide the location, date, person's name, and duration of interaction:

Name	Date	Location	Duration (minutes)

6. Describe the level of contact you had with the case while they had symptoms (check all that apply):

☐Within 3 feet (close contact) for over 1 hour duration

☐Within 3 feet of case for less than 1 hour duration

☐Had a brief casual contact (i.e. touch, shaking hands, hug etc.)

☐Other, please describe_____

☐None

7. Did you engage in any of the following behaviors with the case (check all that apply):

☐Touch

☐Touch bedding or clothing or other objects that may have had bodily fluids on them

☐Share food or drinks with them

☐Eat/drink food prepared by them

☐Have sex with them

☐Kiss them

☐Sleep or lie in the same bed with them

☐Provide care for them, for example (check all that apply):

☐Cleaned/wiped bodily fluids (sweat, vomit, diarrhea, i.e. provide personal care (wash/dress))

☐Did laundry for the patient

☐Other,

specify:_____

8. If you answered yes to any of the questions in question #4, specify length of time the contact was with the case, the location, and date for each interaction:

Activity/Interaction	**Date**	**Length of time (minutes)**	**Location**

9. Did you have contact with blood or body fluid(s) from the case while they had symptoms?

☐Yes

☐No

10. What Body Fluid(s) did you contact? (check all that apply)

☐Blood ☐Vomitus ☐Stool ☐Saliva ☐Sweat
☐Urine ☐Tears ☐Breast Milk ☐Respiratory/Nasal Secretions
☐Semen ☐Vaginal Fluid ☐Cerebral spinal Fluid (CSF)
☐Other, specify:_____

11. If the case died, did you touch the body?

☐Yes ☐No

If yes, please describe the level of contact you had with the body_____

_____

Healthcare Contacts:

12. What was the nature of your healthcare contact with the case while they were symptomatic? (**check all that apply**)

☐Attend to the case's direct care in a hospital/outpatient setting (physician, nurse, EMS, etc.)
☐Perform laboratory services (phlebotomy, other specimen collection, laboratory testing, etc.)
☐Perform custodial services (launder linens, disinfect equipment, clean case's room)
☐Attend to the case's food service needs (deliver food tray to room, pick up food tray, etc.)
☐Registration/triage/initial healthcare assessment (i.e. vitals, pulse ox, etc…)
☐Radiological exam (i.e. CT scan, X-Ray, MRI, ultrasound, etc..)
☐Patient Transport Services
☐Perform an autopsy, surgery, or other medical examination
☐Other, specify:_____

13. In your own words, briefly describe the nature of your healthcare interaction with the case:

_____
_____
_____

14. Describe the level of physical contact you had with the case while they had symptoms (check all that apply):

☐Within 3 feet of the case **with** appropriate PPE
☐Within 3 feet of the case while **not wearing** PPE
☐In case's room or area of care **with** appropriate PPE
☐In case's room or area of care while **not wearing** PPE
☐Had a brief casual contact (i.e. touch, triage, transport etc.)
☐Other, please describe_____
☐None

15. While you were near the EVD case, did you engage in any of the following behaviors?

☐Touch
☐Touch bedding or clothing or other objects that may have had bodily fluids on them
☐Provide care for them
    ☐Cleaned/wiped bodily fluids (sweat, vomit, diarrhea, i.e. provide personal care (wash/dress))
    ☐Cleaned/wiped patient's area (bed linens/bathroom/washing clothes)
☐Other, specify:_____

If so, please describe where the contact occurred:

Date	Name of Location	Address of Location	Details of Contact

16. Did you have contact with blood or body fluid(s) from the case while they had symptoms?
☐Yes
☐No

17. What Body Fluid(s) did you contact? (check all that apply)
☐Blood ☐Vomitus ☐Stool ☐Saliva ☐Sweat
☐Urine ☐Tears ☐Breast Milk ☐Respiratory/Nasal Secretions
☐Cerebral spinal Fluid (CSF) ☐Vaginal Secretions ☐Other, specify:_____

18. What was your type of contact with bodily fluids (check all that apply):
☐No direct contact due to appropriate PPE
☐Contact with your intact skin
☐Contact with your broken (fresh cut, burn, abrasion that had not dried) skin or mucous membranes
☐Other, specify:_____

Please describe the exposure (provide date(s)):
_____
_____
_____

19. What personal protective equipment was used for case interactions (check all that apply):
☐Gloves ☐Tyvek Suit ☐Leg Covers ☐Surgical Mask ☐Double Gloves
☐Face Shield ☐Shoe Covers ☐Gown ☐Glasses/goggles ☐Facemask
☐Surgical scrub suit

20. Were there any deviations from the use of recommended levels of PPE, or malfunctions of PPE when interacting with the EVD case, handling specimens, or contacting a contaminated environment? If yes, describe (please provide date(s)):
_____
_____
_____

21. Laboratory only: Did you process blood, or bodily fluid without appropriate PPE? If yes, describe (please provide date(s)):
_____
_____
_____

22. If the case died, did you touch the body?

☐Yes ☐No

If yes, please describe the level of contact you had with the body_____

_____

23. Did you have any other contact with the case not previously mentioned?

Risk Classification:

☐High Risk

- Direct exposure to body fluids of the EVD patient
- Direct care of a confirmed or suspected EVD patient without PPE
- Laboratory worker processing body fluids without appropriate laboratory biosafety precautions
- Participation in funeral/burial rites or body preparation of the EVD patient without appropriate PPE

☐Low Risk

- No high risk exposures identified
- Direct brief contact with an EVD patient (e.g., shaking hands)
- Close contact with an EVD patient (within 3 feet (1 meter) for a prolonged period)

☐No known risk

- No high or low risk exposures identified
- No contact with the EVD patient

Follow-up Actions:

☐Active surveillance (health department to monitor temperature and symptoms twice daily)

☐Passive surveillance (contact to monitor own temperature and symptoms twice daily)

☐No further follow-up required (no known risk or last exposure >21 days)

Form Approved
OMB No. 0920-1011
Exp Date: 3/31/2017

Ebola Virus Disease Case Contact Questionnaire

Interviewee name: _____ DRAFT 09/30/2014 State ID No.: _____

Ebola Virus Disease Case Contact Questionnaire

The purpose of this questionnaire is to assess the type of contact you may have had with a confirmed or probable case of Ebola Virus Disease (EVD). The information obtained from these questions will determine your risk of exposure to EVD -- high risk, low risk, or no known risk. Depending upon your risk exposure category you may be required to monitor yourself for any signs or symptoms of EVD for 21 days following your last date of contact. A form should be completed per confirmed or probable case of EVD with whom you had contact.

Important terms:

Symptoms	Fever (>101.5°F or 38.6°C); Severe headache; Muscle pain; Weakness; Diarrhea; Vomiting; Abdominal pain; Unexplained hemorrhage (bleeding or bruising).
Close contact	A.) Being within 3 feet (1 meter) of an EVD patient or within the patient's room or care area for a prolonged period of time (e.g., household member, healthcare personnel) while not wearing personal protective equipment, OR B.) Having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended personal protective equipment. NOTE: Brief interactions, such as walking by a person, do NOT constitute close contact.
Personal Protective Equipment	Protective equipment used for standard, contact, and droplet precautions (e.g., gloves, impermeable gown, eye protection, facemask, etc.)

Interviewer Information:

Date of interview: _____ *(M, D, Yr)*

Interviewer: _____

Affiliation: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone *(cell)*: _____ Telephone *(office)*: _____

Email: _____

Interviewee name: _____ State ID No.: _____

EVD Patient Information:

EVD patient name: _____ State ID No.: _____

Symptom onset date: _____ (MM/DD/YYYY) Date of death *(if applicable)*: _____ (MM/DD/YYYY)

0. What is your position or title?

D _____

1. What department (s) do you work in?

D _____

2. Do you work in any healthcare facilities?

D Yes
If yes, specify: _____

D No

3. Did you have close contact with the patient while they had symptoms?

(see important terms on page 1 for definition of close contact and symptoms of EVD)

D No *(If no, then see 'No Known Risk' under risk classification on page x)*

D Yes

4. What was the LAST date of close contact with the patient? _____ (MM/DD/YYYY)

5. What was the nature of your contact with the patient while they were symptomatic? *(check all that apply)*

Healthcare

D Attend to the patient's direct care in a hospital/ outpatient setting *(physician, nurse, EMS, etc.)*

D Perform laboratory services *(phlebotomy, other sample collection, laboratory testing, etc.)*

D Perform custodial services *(launder linens, disinfect equipment, clean patient's room)*

D Attend to the patient's food service needs *(deliver food tray to room, pick up food tray, etc.)*

D Perform surgery or other medical examination

(question continued on next page)

Interviewee name: _____ State ID No.: _____

5. What was the nature of your contact with the patient while they were symptomatic? *(continued)*

D Describe: _____

Length oftime *(hours):* __ __ __ __

6. Did you have contact with blood or other body fluid(s) from the patient while they had symptoms?

D No

D Yes

7. What body fluid(s) did you contact? *(check all that apply)*

D Blood D Saliva D Tears D ~~Vaginal fluid~~

D Vomitus D Sweat D ~~Breast milk~~ D Respiratory Nasal secretions

D Stool D Urine D Semen D Cerebral spinal fluid (CSF)

D Other, specify: _____

8. Was your contact with body fluids the result of an occupational exposure?

D No

D Yes *If yes, facility name:* _____

9. What was your type of contact with the body fluids? *(check all that apply)*

D No direct contact due to appropriate PPE

D Contact with your intact skin

D Contact with your broken skin *(fresh cut, burn, abrasion that had not dried)*

D Contact with your mucous membranes *(eyes, nose, mouth, etc.)*

D Other, specify: _____

10. What personal protective equipment was used? *(check all that apply)*

D Gloves D Double gloves D Glasses/goggles

D Tyvek suit D Face shield D Facemask

D Leg covers D Shoe covers D Surgical scrub suit

D Surgical mask D Gown *(fluid resistant and impermeable)*

D Double gown *(fluid resistant and impermeable)*

11. Did you have any other contact with the patient not previously mentioned?

12. Where would you seek healthcare if you developed a fever or symptoms consistent with Ebola? (list facility)

_____

Risk Classification:

D High Risk

- Direct exposure to body fluids of the EVD patient
- Direct care of a confirmed or suspected EVD patient without PPE
- Laboratory worker processing body fluids without appropriate laboratory biosafety precautions
- Participation in funeral/burial rites or body preparation of the EVD patient without appropriate PPE

D Low Risk

- No high risk exposures identified
- Direct brief contact with an EVD patient *(e.g., shaking hands)*
- Close contact with an EVD patient *(within 3 feet (1 meter) for a prolonged period)*

D No known risk

- No high or low risk exposures identified
- No contact with the EVD patient

Follow-up Actions:

D No further follow-up required *(no known risk or last exposure >21 days).*

D Fever monitoring recommended *(high and low risk only)*

Last exposure date: _____ *(M, D, Yr)*

Last day of monitoring *(day 22):* _____ *(M, D, Yr)*

Who will conduct the follow-up for fever and symptom monitoring?

Contact: _____ Telephone: _____

Affiliation: _____

(hand out paperwork for monitoring - fever / symptom log and guidance document if contact develops symptoms)

D Fever monitoring recommended but respondent is refusing follow-up

D Respondent has had a fever or other symptom(s) of EV since having contact with the patient

First symptom: _____ Onset date: _____ *(M, D, Yr)*

Temperature: ____ °F Fever onset date: _____ *(M, D, Yr)*

Where will the respondent be evaluated? _____

(if the respondent is symptomatic complete a case investigation form)

Respondent Information:

Respondent: _____

Date of birth: _____ *(M, D, Yr)* Sex: **D** Female **D** Male

Address: _____

City: _____ State: _____ Zip code: _____

Telephone *(cell):* _____ Telephone *(home):* _____ Telephone *(work):* _____

Email: _____

Form Approved
OMB No. 0920-1011
Exp Date: 3/31/2017

Healthcare Worker Interview Form 10/11/2014 (Interactions since 30 September 2014)

Healthcare Worker Interview Form 10/11/2014 (Interactions since 30 September 2014)

Dates of exposure (range): **EVD Patient name:**

Health worker name: Person completing form:

Health worker address:

County:
Health worker phone number:
Health worker Phone number (alternate):

Specialty (circle all that apply):

Lab Radiology Environmental Services

MICU Respiratory Therapy Other (specify): _____

Screening Questions: ***(if the person answers "NO" to both questions, this person is NOT a contact, skip to classification section and end the questionnaire)***

1. Did you ever enter (check all that apply): ☐Ante-Room ☐Case Room ☐MICU floor ☐None
   What PPE did you wear (include dates)? _____
2. Did you ever have contact with the case patient samples? ☐Yes ☐No
   What PPE did you wear? Plexiglass shield used? _____
3. Briefly describe the nature of your contact with the patient, patient's blood or body fluids, specimens, or potentially contaminated surfaces (please provide date(s)):

If the contact answered "YES" to screening question 1 or 2:

1. Any deviations from the use of recommended levels of PPE, or malfunctions of PPE when interacting with the EVD case, handling specimens, or contacting a contaminated environment? If yes, describe (please provide date(s)):
2. Any known exposure to your skin or mucous membranes with patient **blood or body fluids**? If yes, describe (please provide date(s)):
3. Any known **skin to skin** exposure to patient (without PPE)? If yes, describe (please provide date(s)):
4. Laboratory only: Did you process blood, or bodily fluid **without appropriate PPE**? If yes, describe (please provide date(s)):

Classification:

5. ☐High Risk ☐Low Risk ☐No Known Exposure ☐Not a contact

Form Approved
OMB No. 0920-1011
Exp Date: 3/31/2017

Healthcare Worker Supplemental Interview Form

Patient name: **Interviewer:**

1. Which patients did you care for?

NP ED AV

2. Dates cared for Ebola patients (circle):

9/29 9/30 10/1 10/2 10/3 10/4 10/5 10/6 10/7 10/8 10/9 10/10 10/11 10/12 10/13 10/14

3. Job category:

Nurse Radiology Physician Respiratory therapy Other

4. Did you help patient to the commode?

Yes No

5. Dates entered patient room (circle):

9/29 9/30 10/1 10/2 10/3 10/4 10/5 10/6 10/7 10/8 10/9 10/10 10/11 10/12 10/13 10/14

6. Sites care provided (circle):

ER ICU Both Neither

7. Dates touched patient (circle):

9/29 9/30 10/1 10/2 10/3 10/4 10/5 10/6 10/7 10/8 10/9 10/10 10/11 10/12 10/13 10/14

8. Can you estimate cumulative time in the room in hours (circle)?

<1 hour 1 to 2 hours 59 minutes 3 to 5 hours 59 minutes 6 or more hours

9. Did you ever not use bleach wipes to clean up stool or blood that splashed on your PPE (circle)?

Yes No

10. Days with visible soiling of PPE with blood (circle):

9/29 9/30 10/1 10/2 10/3 10/4 10/5 10/6 10/7 10/8 10/9 10/10 10/11 10/12 10/13 10/14

11. Days with visible soiling of PPE with stool (circle):

9/29 9/30 10/1 10/2 10/3 10/4 10/5 10/6 10/7 10/8 10/9 10/10 10/11 10/12 10/13 10/14

12. Days interacted with rectal tube:

Placed tube (circle):

9/29 9/30 10/1 10/2 10/3 10/4 10/5 10/6 10/7 10/8 10/9 10/10 10/11 10/12 10/13 10/14

Changed bag (circle):

9/29 9/30 10/1 10/2 10/3 10/4 10/5 10/6 10/7 10/8 10/9 10/10 10/11 10/12 10/13 10/14

13. Did you clean up vomit?
    Yes No
14. Did you clean up stool?
    Yes No
15. Did you draw blood?
    Yes No
16. Did you reposition the patient?
    Yes No
17. Did you bathe the patient?
    Yes No

Form Approved
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Exp Date: 3/31/2017

21-day fever and symptom follow-up form for contacts of probable or confirmed Ebola patients

DRAFT 09/30/2014

21-day fever and symptom follow-up form for contacts of probable or confirmed Ebola patients

Name: _____ Age (yrs): _____ Sex: M F

Street address: _____ City, State: _____ Telephone number: _____

Case ID number (from contact listing form): _____ Contact number (from contact listing form): _____

Where did contact with the case occur: _____ Date of last contact with the case (mm/dd/yyyy): _____

Take your temperature twice each day, in the morning and in the evening. Indicate whether you have any of the symptoms listed on this form once each day. Circle 'Y' (*yes*) if you have the symptom and 'N' (*no*) if you don't. **Don't leave any spaces blank.** If you have any of the symptoms, immediately call the public health department at XXX-XXX-XXXX.

Day number (after last contact)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Date																					
Temperature morning																					
Temperature evening																					
Malaise (feeling unwell)*	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Muscle pain	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Headache	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Sore throat	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Vomiting	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Diarrhea	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Rash	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Unexplained bleeding**	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N

*Malaise is a general feeling of bodily discomfort or feeling badly

**Unexplained bleeding means bleeding from your mouth or nose, bloody diarrhea, or coughing up blood, or bruising under the skin

Modified: 09/19/2014

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

CCHF Case Investigation Questionnaire

CCHF Case Investigation Questionnaire

№ ☐☐☐

Name of examiner _____ Date of filling ___/_____/_____

☐☐☐☐☐ № of history record
Hospitalization ☐ Y ☐ N
Hospital name_____
Date of hospitalization ___/_____/2011

Demographic data
Date of birth _____/_____/_____ Sex ☐м ☐F
Residence located in:
Rayon:_____ Sub-district:_____
Employed ☐ yes ☐ no

Occupation _____
Kind of activity _____

Risk factors for CCHF (within 2 weeks before developing a fever)
Tick bite ☐ Y ☐ N
Date of tick bite: _____/_____/_____

Livestock activity ☐ Y ☐ N
Species contacted:_____

Slaughtering livestock ☐ Y ☐ N
Species contacted:_____

Butchering/handling raw meat ☐ Y ☐ N
Type of meat handled(species):_____

Nursing for person with bleeding ☐ Y ☐ N

Handling ticks with bare hands ☐ Y ☐ N

Seeking of medical care due to tick bite ☐ Y ☐ N
Date of seeking of medical care:_____/_____/_____

Medical facility:_____

Geographic location of tick bite Rayon:_____ Sub-district:_____

Number of ticks removed:____
Tick ID # _____ Species:_____

Clinical data
Date of symptom/illness onset _____/_____/2011 resolved: _____/_____/2011
Fever ☐ Y ☐ N onset date: _____/_____/2011 resolved: _____/_____/2011
Headache ☐ Y ☐ N onset date: _____/_____/2011 resolved: _____/_____/2011
Myalgia/muscle ache ☐ Y ☐ N onset: _____/_____/2011 resolved: _____/_____/2011
Vomiting ☐ Y ☐ N onset date: _____/_____/2011 resolved: _____/_____/2011
Diarrhea ☐ Y ☐ N onset date: _____/_____/2011 resolved: _____/_____/2011

Hemorrhagic syndrome ☐ Y ☐ N

Hemorrhagic rash ☐ Y ☐ N Date of onset _____/_____/2011 resolved: _____/_____/2011
Rash Location: ☐Head/face ☐Body ☐Arms/Legs

Hemorrhages/bruising ☐ Y ☐ N Date of onset_____/_____/2011 resolved: _____/_____/2011
Hemorrhage Location: ☐Head/face ☐Body ☐Arms/Legs

Bleeding ☐ Y ☐ N Date of onset_____/_____/2011 resolved: _____/_____/2011
Bleeding Location: ☐Gastrointestinal ☐Urogenital ☐Nasal ☐Respiratory

Daily body temperature (maximum value) and blood characteristics

Date (dd.mm)	Temperature °C	Thrombocyte count	White blood cell count	Red blood cell count	Hemoglobin	Alanine Transferase (ALT)	Aspartate Transferase (AST)

(Other symptoms/attributes):_____

Treatment
Ribavirin ☐ Y ☐ N
Date of treatment start:____/_____/2011
Date of end of treatment: _____/_____/2011г.
Dosage:
_____
_____
Mode of administration: Oral ☐ Y ☐ N Intravenous ☐ Y ☐ N

Immune plasma ☐ Y ☐ N
Date of treatment start: _____/_____/2011г.
Date of end of treatment: _____/_____/2011г.
Total volume/units given: _____

Date of discharge from the hospital: _____/_____/2011г.

Diagnosis: _____
☐Suspect ☐Probable ☐Confirmed ☐Negative

Outcome
☐ survived ☐ died ☐ unknown

If patient died, date of death: ____/_____/2011

Diagnostic Tests Performed

Blood collection #1
Date of blood collection ___/_____/_____

CCHF diagnostic testing

Tests	**Result**		
IgM ELISA	☐ positive	☐ Negative	☐ Uncertain
IgG ELISA	☐ positive	☐ Negative	☐ Uncertain
Antigen ELISA	☐ positive	☐ Negative	☐ Uncertain
PCR	☐ positive	☐ Negative	☐ Uncertain

Other relevant test results:_____

Blood collection #2
Date of blood collection ___/_____/_____

CCHF diagnostic testing

Tests	**Result**		
IgM ELISA	☐ positive	☐ Negative	☐ Uncertain
IgG ELISA	☐ positive	☐ Negative	☐ Uncertain
Antigen ELISA	☐ positive	☐ Negative	☐ Uncertain
PCR	☐ positive	☐ Negative	☐ Uncertain

Other relevant test results:_____

Blood collection #3
Date of blood collection ___/_____/_____

CCHF diagnostic testing

Tests	**Result**		
IgM ELISA	☐ positive	☐ Negative	☐ Uncertain
IgG ELISA	☐ positive	☐ Negative	☐ Uncertain
Antigen ELISA	☐ positive	☐ Negative	☐ Uncertain
PCR	☐ positive	☐ Negative	☐ Uncertain

Other relevant test results:_____

Tissue Collection
Date of Tissue collection: ___/_____/_____
Tissues sampled: ☐Liver ☐Spleen ☐Blood clot ☐Lymph node ☐other:

CCHF diagnostic testing

Tests	**Result**		
Antigen ELISA	☐ positive	☐ Negative	☐ Uncertain
PCR	☐ positive	☐ Negative	☐ Uncertain

Other relevant test results:_____

Tick testing for CCHF
Date of test: ___/_____/_____

Antigen ELISA	☐ positive	☐ Negative	☐ Uncertain
PCR	☐ positive	☐ Negative	☐ Uncertain

Form Approved
OMB No. 0920-1011
Exp. Date 3/31/2017

Crimean-Congo Hemorrhagic Fever

Knowledge, Attitudes, and Practice Survey

October 2014
Tbilisi, Georgia

LABEL

SCREENING FORM

Interview Date:
Interviewer Name:

Household Number Assigned:
Location (Village/Rayon/District):
GPS Coordinates:

1. If you are unable to interview this household state why:
    a) No one is home
    b) No one meets the inclusion criteria in the house (circle all that apply):
        i. Less than 18 years old
        ii. Cannot give consent
        iii. Lived in the household/immediate area for less than 2 months
    c) Declined to participate (Go to Consent Form Question 2b)
    d) Abandoned property (Go to next question)
    e) Commercial property (Go to next question)
    f) Other, explain _____

2. If the property was abandoned or is commercial property, please enter the new GPS coordinates of the next household chosen? _____

CONSENT FORM

LABEL

Investigation of Crimean-Congo hemorrhagic fever in Georgia, 2014

Hello my name is _____, I am with the Centers for Disease Control and Prevention on behalf of the National Center for Disease Control and Public Health. During the past few months in Georgia there have been some cases of a disease called Crimean-Congo hemorrhagic fever. We are trying to better understand why some Georgians have become ill with Crimean-Congo hemorrhagic fever. We would like to administer a brief questionnaire to you and to draw blood from you. We hope to use the results of our investigation to help prevent future illness in Georgians.

We would like to take a small sample of blood from your arm to find out if you were infected with the Crimean-Congo hemorrhagic fever virus recently or in the past. There may be a small risk with the blood sample collection including discomfort, bruising, or bleeding at the site of the blood draw. The blood specimen will be stored at Lugar laboratories for up to two years in the event that repeat Crimean-Congo hemorrhagic fever testing needs to be performed. The sample you provide will not be used for any other research.

The benefits of participating in this investigation and the testing will be that you will know if you were infected with the virus, and the information from this investigation will help the Georgian government prevent people from becoming infected with this virus in Georgia in the future.

All the information you share with us will be kept completely private. You are free to choose whether or not to participate in this investigation, and you can withdraw from any part of this investigation at any time.

1. **Would you be willing to take about 30 minutes to answer some questions about yourself and your activities prior to your illness?**

   a) **If yes:** Thank you. <go to question 2>
   b) **If no:** Why don't you want to take the survey?

   _____

   Would another day or time be more convenient for you? Yes No

If yes: When? _____

If no: Can you give us some very basic information?

i. Residence: (village/rayon/district)_____

ii. Date of Birth: __ __ /__ __ / __ __ __ __
D D M M Y Y Y Y

iii. Sex (circle one): Male, Female

iv. Nationality (circle one): Georgian, Azery, Armenian

v. Highest education level:
   a. Elementary
   b. Secondary
   c. Vocational
   d. Higher
   e. None
   f. Other: _____

vi. What daily activity do you perform for greater than 6 hours a day?
   a. Farmer
   b. Herder
   c. Gardening/Work in the Field
   d. Slaughterhouse worker
   e. Butcher
   f. Healthcare worker
   g. Veterinarian
   h. Work in an office
   i. Other_____

vii. What is your monthly household income?
   a. <100 Lari
   b. 100-500 Lari
   c. 501-1000 Lari
   d. 1001-1500 Lari
   e. 1501-2000 Lari
   f. 2001-3000 Lari
   g. >3001 Lari

viii. Do you receive social security?
   a. Yes
   b. No

ix. How much land do you own?
   a. I rent the land
   b. <1000m^2
   c. 1000-2000m^2
   d. 2001-3000m^2
   e. 3001-4000m^2
   f. 4001-8000m^2
   g. >8000m^2

2. **Would you be willing to have your blood drawn?**
    a. **If yes:** Thank you. Let's get started with the questions. <Go to the KAP questionnaire>
    b. **If no:** Why don't you want to have your blood drawn?

    _____

    Can you give us some very basic information?

    i. Residence: (village/rayon/district)_____
    ii. Date of Birth: __ __ /__ __ / __ __ __ __
        D D M M Y Y Y Y
    iii. Sex (circle one): Male, Female
    iv. Nationality (circle one): Georgian, Azery, Armenian
    v. Highest education level:
        a. Elementary
        b. Secondary
        c. Vocational
        d. Higher
        e. None
        f. Other: _____
    vi. What daily activity do you perform for greater than 6 hours a day?
        a. Farmer
        b. Herder
        c. Gardening/Work in the Field
        d. Slaughterhouse worker
        e. Butcher
        f. Healthcare worker
        g. Veterinarian
        h. Work in an office
        i. Other_____
    vii. What is your monthly household income?
        a. <100 Lari
        b. 100-500 Lari
        c. 501-1000 Lari
        d. 1001-1500 Lari
        e. 1501-2000 Lari
        f. 2001-3000 Lari
        g. >3001 Lari
    viii. Do you receive social security?
        a. Yes
        b. No
    ix. How much land do you own?
        a. I rent the land
        b. <1000m^2
        c. 1000-2000m^2
        d. 2001-3000m^2

e. 3001-4000m^2
f. 4001-8000m^2
g. >8000m^2

Thank you so much for your time and consideration.

SURVEY

LABEL

Introduction

Note: When administering the following survey, do not prompt any of the multiple choice answers; please have the participant state their own answers.

To the interviewee: "Thank you for being willing to participate in this survey. I am going to start by asking you basic questions about yourself to get to know you better. Please note that your name and any other identifying information will not be collected during this survey. If you want to have the survey stopped at any time or for any reason, please tell us immediately."

Demographics

1. Date of birth (DD/MM/YYYY): _____
2. Sex:
    a. Male
    b. Female
3. Nationality:
    a. Georgian
    b. Azery
    c. Armenian
    d. Other: _____
4. Residence:
    a. Rural
    b. Urban
5. Household Size (including the participant): _____
6. Are you registered to vote?
    a. Yes
    b. No
7. Highest education level: (one answer only)
    a. Elementary
    b. Secondary
    c. Vocational
    d. Higher
    e. None

f. Other: _____

8. What daily activity do you perform for greater than 6 hours a day? (circle one answer only)
    a. Farmer
    b. Herder
    c. Gardening/Work in the Field
    d. Slaughterhouse worker
    e. Butcher
    f. Healthcare worker
    g. Veterinarian
    h. Work in an office
    i. Other_____
9. What is your monthly household income?
    a. <100 Lari
    b. 100-500 Lari
    c. 501-1000 Lari
    d. 1001-1500 Lari
    e. 1501-2000 Lari
    f. 2001-3000 Lari
    g. >3001 Lari
    h. I don't know
10. Do you receive social security?
    a. Yes
    b. No
11. How much land do you own?
    a. I rent the land
    b. <1000m^2
    c. 1000-2000m^2
    d. 2001-3000m^2
    e. 3001-4000m^2
    f. 4001-8000m^2
    g. >8000m^2

Risk Factors

12. Do you own or take care of animals? (circle all the apply)
    a. No
    b. If yes, what type?
        i. Sheep
        ii. Goats
        iii. Cattle
        iv. Buffalo
        v. Chickens
        vi. Horses
        vii. Donkeys
        viii. Other _____

13. In the last four months, have you performed the following activities (circle all the apply):
    a. Herding
        i. No
        ii. Sheep
        iii. Goats
        iv. Cattle
        v. Buffalo
        vi. Other_____
    b. Have you assisted an animal birth?
        i. Have assisted in animal birthing but have used PPE (gloves, gowns, boots)
        ii. Have assisted in animal birthing but have **not** used PPE
        iii. Have not assisted in animal birthing
    c. Slaughtering
        i. No
        ii. Sheep
            1. Slaughter sheep using PPE (gloves, gowns, boots)
            2. Slaughter sheep without PPE (gloves, gowns, boots)
        iii. Goats
            1. Slaughter goats using PPE (gloves, gowns, boots)
            2. Slaughter goats without PPE (gloves, gowns, boots)
        iv. Cattle
            1. Slaughter cattle using PPE (gloves, gowns, boots)
            2. Slaughter cattle without PPE (gloves, gowns, boots)
        v. Buffalo
            1. Slaughter buffalo using PPE (gloves, gowns, boots)
            2. Slaughter buffalo without PPE (gloves, gowns, boots)
        vi. Other_____
            1. Slaughter animals using PPE (gloves, gowns, boots)
            2. Slaughter animals without PPE (gloves, gowns, boots)
    d. Butchering/handling raw meat
        i. No
        ii. Sheep
        iii. Goats
        iv. Cattle
        v. Buffalo
        vi. Other_____
    e. Handled ticks with bare hands
        i. No
        ii. Removed ticks from animal and threw is out
        iii. Removed ticks from animals and killed with bare hands
        iv. Removed ticks from yourself and threw it out
        v. Removed ticks from yourself and killed with bare hands

vi. Other_____

f. Worked in a health care setting
   i. No
   ii. Primary healthcare
   iii. Clinic
   iv. Hospital
   v. Other_____
g. Drank unpasteurized milk
   i. Yes
   ii. No
h. Gardening
   i. Yes
   ii. No
i. Any other outdoor activity not previously asked:
   i. None
   ii. Hiking
   iii. Camping
   iv. Hunting
   v. Fishing
   vi. Picnicking outside
   vii. Other_____

14. In the last four months, have you had a tick bite?
    a. No
    b. Yes, describe each situation:

Date of Tick Bite (MM/YYYY)	Where? (village/rayon/region)	Where? (body location)	How much time did it take to get it removed after it was found?

15. Any travel or migration outside your rayon in the last four months?
    a. No
    b. Yes, describe:

Location (village/rayon/region)	Reason	Dates

16. Were you visited by the household educational campaign last few months?
    a. Yes
    b. No

c. I don't remember

KAP Information

Reminder: When administering the survey, do not prompt any of the multiple choice answers; please have the participant state their own answers.

To the interviewee: "Now I am going to ask you questions regarding what you know about Crimean-Congo Hemorrhagic Fever and what you do to protect yourself and your animals."

Knowledge

17. Have you ever heard about Crimean-Congo Hemorrhagic Fever, also known as CCHF?
    a. Yes (proceed to question 2)
    b. No (proceed to **Attitudes section**)
    c. I don't know
18. Where have you learned/heard about CCHF? (circle all that apply)
    a. School
    b. Media
        i. TV
        ii. Radio
        iii. Newspaper/Magazines
        iv. Pamphlets
            1. Where did you receive it? _____
        v. Posters
            1. Where did you see it? _____
    c. Educational campaign last few months (July-October)
    d. Training courses
    e. Health care worker
    f. Know someone who had CCHF
        a. Who? _____
    g. I don't know
    h. Other_____
19. What are ways in which a human can become infected? (circle all that apply)
    a. Bite from a tick
    b. Crushing a tick with bare hands
    c. Contact with blood from infected animals
    d. Contact with birthing tissues/fluids from infected animals
    e. Eating raw, infected meat
    f. Contact with blood from people sick from CCHF
    g. Drinking unpasteurized milk
    h. I don't know
    i. Other _____

20. What activities can put you at risk of getting the disease? (circle all that apply)
    a. Working with livestock
    b. Working in produce/vegetable/grain fields
    c. Working in the garden
    d. Working in a rural, woody area
    e. Slaughtering animals
    f. Butchering meat
    g. Working in a hospital
    h. Being a abattoir/slaughterhouse worker
    i. Working as a veterinarian
    j. Working as a health care worker
    k. I don't know
    l. Other_____
21. What are the signs and symptoms of CCHF? (circle all that apply)
    a. Fever
    b. Headache
    c. Nausea/Vomiting
    d. Diarrhea
    e. Muscle pain
    f. Joint pain
    g. Weakness
    h. Cough
    i. Blood in the urine
    j. Blood in the stool (black or bright red)
    k. Coughing blood
    l. Red eyes
    m. I don't know
    n. Other_____

Attitudes

22. Do people frequently get bitten by ticks in your community?
    a. Yes
    b. No
    c. I don't know
23. Do you think ticks are a problem in your community?
    a. Yes
    b. No
    c. I don't know
24. Do you think there are more ticks this year than previously?
    a. Yes
    b. No
    c. I don't know
25. Do you think CCHF is a problem in your community?

a. Yes
b. No
c. I don't know

26. Do you think CCHF is something you should be worried about?
    a. Yes
    b. No
    c. I don't know
27. Do you think you can protect yourself from CCHF?
    a. Yes
        i. How? _____
    b. No
    c. I don't know

Practices

28. Do you have any interaction with ticks during your **job**?
    a. Yes
        i. Please describe_____
    b. No
29. Do you have any interaction with ticks at **home**?
    a. Yes
        i. Please describe_____
    b. No
30. If you interact with ticks, what method do you use to remove ticks off **yourself**? (circle only one answer)
    a. Remove by hand
    b. Remove with tweezers
    c. Go to a hospital/health care center
    d. I don't interact with ticks
    e. I don't remove ticks
    f. Other_____
31. What do you do to protect **yourself** from ticks/CCHF? (circle all that apply)
    a. Protective clothing (i.e. long pants, socks, etc.)
        i. How often? Always Sometimes Never
    b. Treat your clothing with repellent
        i. How often? Always Sometimes Never
    c. Insect repellent on yourself
        i. How often? Always Sometimes Never
    d. Use pesticides in the environment
        i. How often? Always Sometimes Never
    e. Avoid woody/rural areas
        i. How often? Always Sometimes Never
    f. Nothing
    g. I don't know

h. Other_____
    i. How often? Always Sometimes Never

32. What care would you seek, if any, if you experienced symptoms of CCHF (fever, muscle aches, nausea/vomiting, bloody stools or urine, etc.)? (circle one answer only)
    a. Go to a hospital/healthcare facility
        i. Primary healthcare
        ii. District
        iii. Regional
        iv. Tbilisi ID hospital (IPC)
        v. Any other clinic in Tbilisi:_____
        vi. Other:_____
    b. Stay at home
    c. Try local pharmacy
    d. Go to a local healer
    e. Nothing
    f. Other_____

The following questions refer to livestock; if the participant said NO to **Question 12**, skip to the question below and proceed to the **Educational Campaign** section.

33. How do you prevent ticks for your animals? (circle all that apply)
    a. Use insecticides/acaricide
        i. Spray
        ii. Pour on
        iii. Other_____
    b. Injectable medication
    c. Nothing
    d. Other_____
34. What method do you use to remove ticks off your livestock? (circle one answer only)
    a. Remove by hand
    b. Remove with tweezers
    c. Go to a veterinarian
    d. Pour liquid/mixture onto the tick/animal
        What kind?
        i. Oil
        ii. Alcohol
        iii. Insecticide
        iv. Other_____
    e. There's never been a tick on my animal(s)
    f. Nothing
    g. Other_____

Educational Campaign

Note: If the participant answered no to **Question 16** and/or is not from the following regions, skip this section and proceed to the **Past Illness** section.

Please check which one applies:

- o Samtskhe-Javakheti Region
  - · Borjomi
- o Shida Kartli Region
  - · Khashrui
- o Shida Kartli Region
  - · Kreli, Gori, Kaspi

To the interviewee: "Now I am going to ask you questions about the educational campaign that was performed recently regarding Crimean-Congo Hemorrhagic Fever."

35. Has your understanding of CCHF changed since the educational campaign? (circle all the apply)
    a. Yes
        i. I understand how CCHF is transmitted
        ii. I understand the signs and symptoms
        iii. I know ways to protect myself/others
        iv. Other_____
    b. No
        i. The information was not useful
        ii. I didn't understand the information
        iii. I already knew all about CCHF
        iv. Other_____
    c. I don't know
36. Has your perception of CCHF changed since the educational campaign? (circle all that apply)
    a. Yes
        i. I am more aware of CCHF
        ii. I am aware this is a problem in the community
        iii. I am aware this is a problem in Georgia
        iv. I believe protective equipment/procedures are important
        v. I am aware that CCHF can be dangerous
        vi. I am concerned about my safety
        vii. I am concerned about my family/community's safety
        viii. I am concerned about my job
        ix. Other_____
    b. No
        i. The information was not useful

ii. I didn't understand the information
iii. I already knew all about CCHF
iv. Other_____

c. I don't know

37. Has the way you protect yourself changed since the educational campaign? (circle all that apply)
    a. Yes
        i. I wear long shirts/long pants
        ii. I use repellent
        iii. I use insecticides
        iv. I avoid outdoor/woody areas
        v. Other_____
    b. No
        i. The information was not useful
        ii. I didn't understand the information
        iii. I already knew how to protect myself
        iv. I don't like wearing protective clothing
        v. I don't like using repellent
        vi. I don't like using insecticides
        vii. Other_____
    c. I don't know
38. Has the way you interact with ticks for both yourself and livestock changed since the educational campaign? (circle all that apply)
    a. Yes
        i. I don't handle ticks with my bare skin
        ii. I remove ticks immediately
        iii. I use repellent
        iv. I use insecticides
        v. I use injections
        vi. I consult a healthcare worker
        vii. I consult the veterinarian
        viii. Other_____
    b. No
        i. The information was not useful
        ii. I didn't understand the information
        iii. I already knew how to handle ticks properly
        iv. Other_____
    c. I don't know

Past Illness

39. Have you ever been diagnosed with CCHF?
    a. No
    b. If yes, describe:
        i. Date:
        ii. Where were you diagnosed:
        iii. What symptoms did you have (choose all answers that apply)?
            a. Fever
            b. Headache
            c. Nausea/Vomiting
            d. Diarrhea
            e. Muscle pain
            f. Weakness
            g. Cough
            h. Blood in the urine
            i. Bloody or black stools
            j. Coughing blood
            k. Bleeding from the gums
            l. Other_____

To the interviewee: "Now I am going to ask about any illnesses you might have had in the last five years"

40. Have you ever had both fever and hemorrhaging at the same time in the last 5 years?
    a. No (Skip question 41, and go to question 42)
    b. Yes
        iv. What Date _____
        v. What Symptoms (choose all answers that apply):
            a. Fever
            b. Headache
            c. Nausea/Vomiting
            d. Diarrhea
            e. Muscle pain
            f. Weakness
            g. Cough
            h. Blood in the urine
            i. Bloody or black stools
            j. Coughing blood
            k. Bleeding from the gums
            l. Other_____
41. Did you seek any care for your symptoms?

a. Yes
    i. Where?_____
    ii. When?_____
b. No
    i. Why not? _____

Recent Illness

To the interviewee: "Now I am going to ask about any illnesses you might have had during the past four months"

42. Have you had any illness in the last four months?
    a. Yes
    b. No (End questionnaire)

43. What are dates for each illness you had in the last four months? (show calendar)

Date Started (DD/MM/YYYY)	Date Ended (DD/MM/YYYY)
1.	
2.	
3.	

44. What signs or symptoms did you have during this illness?

	1st Illness		2nd Illness		3rd Illness	
Signs/Symptoms	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Fever						
Weakness/Lethargy						
Headache						
Body / muscle pain						
Joint pain						
Cough						
Abdominal Pain						
Nausea						
Vomiting						
Diarrhea						
Jaundice (yellowing of the skin)						
Bruising						
Petechiae (small dark purple or dark red dots that don't go away when you push down on them)						
Nose Bleeding						
Bleeding from gums						

Blood in vomitus						
Blood in stool						
Blood in urine						
Coughing blood						
Red Eyes						
Bleeding gums						
Other, please list:						

45. Did you seek any care for your symptoms?
    a. Yes
        i. Where? _____
        ii. When? _____
    b. No
        i. Why not? _____ (End questionnaire)
46. If you were hospitalized, how long were you in the hospital for? _____
47. Did you receive any medications or treatments?
    a. No
    b. Yes
        i. What? _____
        ii. Received medication or treatment from (choose one answer only):
            a. Primary healthcare
            b. District
            c. Regional
            d. Tbilisi ID hospital
            e. Any other clinic in Tbilisi:_____
            f. Local pharmacy
            g. Local healer
            h. Other_____

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

PARENT FOCUS GROUP GUIDE

1. Number of participants:

2. Parent organizations participants represent:

3. How long have you all lived in the area?

4. How large of a problem is suicide in your school? How about your community? Do you think this problem is larger, smaller, or similar to other schools and communities?

5. How has your community been affected by the recent suicides in the community? How have you personally been affected by the recent suicides in the community?

6. How do people in the community respond when a young person dies by suicide?

    a. How does the media respond?
    b. How does the town respond?
    c. How do schools respond?
    d. How do parents respond?
    e. How do young people respond?

7. What are issues in the community that affect the way people think about or respond to suicide?

8. What are issues in the community that you think increases the risk for youth suicide?

9. What are issues in the community that you think decrease the risk for youth suicide?

10. What resources are available in the community to help young people who might be depressed, anxious, or thinking about suicide?

    a. Are resources accessed by young people? Why or why not?

11. What resources are available in the community to help families? Are these resources being accessed? Why or why not?

12. When it comes to addressing the needs and problems of young people, what do you think the community needs most?

13. What additional activities or resources should the community be using to prevent suicide among youth? Who should be responsible for these activities/resources?

    a. What do parents need in order to help prevent suicides among youth?

14. What are barriers to seeking and accessing mental health care/resources? Any particular barriers for youth? Any barriers to accessing family services?

15. What role, if any, has social media played in the recent suicides in the community?

16. What role, if any, had traditional media (newspapers, TV, radio) played in the recent suicides in the community?

17. Is there anything else you think we should know?

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SCHOOL ADMINISTRATOR AND GUIDANCE COUNSELOR INTERVIEW GUIDE

1. I'd like to start by getting a sense for your role at the school.

   Probe for:
   - Length of time associated with school
   - Role in school
   - How would you describe your school's community? What is it like for students? What is student's class load, extracurricular activities, etc.? Teachers? Staff? How are parents involved?
   - What challenges are present for school administration? Teachers? Students?
   - What assets are present for school administration? Teachers? Students?

2. How large of a problem is suicide in your school? How about your community? Do you think this problem is larger, smaller, or similar to other schools and communities?

3. Has your school been affected by the recent suicides in the community? How?

4. How do people in the community respond when a young person dies by suicide?

   a. How does the media respond?
   b. How does the community respond?
   c. How do schools respond?
   d. How do parents respond?
   e. How do you young people respond?

5. What are issues in the school that you think increases the risk for youth suicide?

6. What are issues in the school that you think decrease the risk for youth suicide?

7. What are issues in the community that you think increases the risk for youth suicide?

8. What are issues in the community that you think decrease the risk for youth suicide?

9. Is there something about this community that affects the way people think about or respond to suicide?

10. What resources are available for helping youth who might be depressed, anxious, or thinking about suicide?

    a. At school?
    b. In the larger community?

11. What kind of resources or people do you think might help prevent youth suicide?

    a. At school?
    b. In the larger community?

12. What are the barriers to seeking and accessing mental health care and other resources? Anything particular to youth?
    a. At school?
    b. In the larger community?

13. What role, if any, has social media played in the recent suicides in the community?

14. What role, if any, had traditional media (newspapers, TV, radio) played in the recent suicides in the community?

15. Has your district or school implement activities or policies in response to suicide/suicide-related behaviors among youth in the community? Tell me about the activities and policies and how that process unfolded.

    a. What activities/policies do you believe has been most effective for your school in working to prevent youth suicide?

16. What resources have you received to implement suicide prevention activities? [probe about financial, personnel, and material. Probe about source…who provided this resource? How did you access this resource? What partnerships/other community organizations are involved?]

17. Are activities in your school similar to others across the district? Have tailored any activities to respond to the needs of your school?

18. What suicide prevention activities that are being implemented do you think are the most effective? Why?

19. Are suicide prevention approaches unique or the same relative to other affected schools or the district as a whole?

20. What barriers have you encountered in carrying out these suicide prevention activities? How has the school worked to resolve the barriers?

21. What do you see as the next step in your school/district's implementation of suicide prevention strategies?

22. What additional information do you need in order to integrate suicide prevention strategies into your school(s)?

23. Finally, my last question is, do you have anything else you'd like to add or is there anything else you think is important for us to know?