

Appendix 1 CASE REPORT FORM

Public reporting burden of this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

VIRAL HEMORRHAGIC FEVER CASE INVESTIGATION FORM

Outbreak
Case ID:

Health
Facility
Case ID:

Date of Case Report: ___/___/___ (D, M, Yr)

Section 1. Patient Information

Patient's Surname: _____ Other Names: _____ Age: _____ Years Months
Gender: Male Female Phone Number of Patient/Family Member: _____ Owner of Phone: _____

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

Permanent Residence:

Head of Household: _____ 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 specify: _____

Section 3. Hospitalization Information

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

If yes, Date of Hospital Admission: ___/___/___ (D, M, Yr) Health Facility Name: _____

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)				<input type="checkbox"/> Yes <input type="checkbox"/> No
___/___/___ - ___/___/___ (D, M, Yr)				<input type="checkbox"/> Yes <input type="checkbox"/> No

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**
		___/___/___ - ___/___/___			<input type="checkbox"/> Alive <input type="checkbox"/> Dead, date of death: ___/___/___ (D, M, Y)	
		___/___/___ - ___/___/___			<input type="checkbox"/> Alive <input type="checkbox"/> Dead, date of death: ___/___/___ (D, M, Y)	
		___/___/___ - ___/___/___			<input type="checkbox"/> Alive <input type="checkbox"/> Dead, date of death: ___/___/___ (D, M, Y)	

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

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

2. Did the patient attend a funeral **before** becoming ill? Yes No Unk

If yes, please complete one line of information for each funeral attended:

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

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

If yes, 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:

- | | |
|--|--|
| <p>Animal:</p> <p><input type="checkbox"/> Bats or bat feces/urine</p> <p><input type="checkbox"/> Primates (monkeys)</p> <p><input type="checkbox"/> Rodents or rodent feces/urine</p> <p><input type="checkbox"/> Pigs</p> <p><input type="checkbox"/> Chickens or wild birds</p> <p><input type="checkbox"/> Cows, goats, or sheep</p> <p><input type="checkbox"/> Other; <i>specify</i> _____</p> | <p>Status (check one only):</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> <p><input type="checkbox"/> Healthy <input type="checkbox"/> Sick/Dead</p> |
|--|--|

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 specify: _____