

**General Maritime Contact Investigation Outcome Reporting Form**  
 FAX completed form to the CDC at 404.718.2158; For questions, call 404.639.7147

1. VOYAGE INFORMATION				
CDC/QARS ID#	Arrival date	Departure city/port	Arrival city/port	Index case cabin
2. INDEX CASE CLINICAL AND LAB INFORMATION				
3. PASSENGER CONTACT INFORMATION				
Last name, First name or Unique Identifier	Assigned cabin	Gender	DOB (mm/dd/yy)/Age (yrs)	
4. CONTACT /INTERVIEW INFORMATION				
<b>Were you able to contact this person?</b> <input type="checkbox"/> No, why not? <input type="checkbox"/> Incorrect locating information <input type="checkbox"/> No longer at temporary address but still in the U.S. <input type="checkbox"/> No response <input type="checkbox"/> Returned to country of residence <input type="checkbox"/> Didn't attempt follow-up <input type="checkbox"/> Other, specify _____ (Stop here) <input type="checkbox"/> Yes, date contacted: ___/___/___ Was contact interviewed? <input type="checkbox"/> No, why not? <input type="checkbox"/> Declined <input type="checkbox"/> Lives in different jurisdiction, specify _____ <input type="checkbox"/> Other, specify _____ (Stop here) <input type="checkbox"/> Yes; actual/verified cabin # _____, date of last known contact with index case: ___/___/___ Was this person a known close contact of the index case outside of this voyage (e.g. family member)? <input type="checkbox"/> No <input type="checkbox"/> Yes Was this person a crew member? <input type="checkbox"/> No <input type="checkbox"/> Yes, was this person frequently in close proximity to index case besides sharing living quarters (i.e. work or social)? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: _____				
5. IMMUNITY				
Vaccination or history of disease: <input type="checkbox"/> Not vaccinated <input type="checkbox"/> Vaccinated, date of most recent dose: ___/___/___ <input type="checkbox"/> History of disease <input type="checkbox"/> Immunity established by serology <input type="checkbox"/> Unknown				
6. HEALTH SINCE EXPOSURE				
Did contact report any signs or symptoms? <input type="checkbox"/> No <input type="checkbox"/> Yes; check all that apply: <input type="checkbox"/> Fever (Max temp measured _____°C/F) <input type="checkbox"/> Cough <input type="checkbox"/> Rash <input type="checkbox"/> Coryza <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Sore throat <input type="checkbox"/> Swollen glands <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Jaundice <input type="checkbox"/> Headache <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Unusual bleeding <input type="checkbox"/> Decreased consciousness <input type="checkbox"/> Difficulty breathing/shortness of breath <input type="checkbox"/> Recent onset of focal weakness and/or paralysis <input type="checkbox"/> Other, specify _____				
7. PUBLIC HEALTH INTERVENTION				
Did contact receive prophylaxis for this exposure? <input type="checkbox"/> No, why not? <input type="checkbox"/> Outside window for prophylaxis <input type="checkbox"/> Within window for prophylaxis but declined <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Yes, please indicate what s/he received and include the date(s): <input type="checkbox"/> Antimicrobial drug; specify _____, date received: ___/___/___ <input type="checkbox"/> Vaccination; date received: ___/___/___ <input type="checkbox"/> Immunoglobulin; date received: ___/___/___ <input type="checkbox"/> Other, specify: _____, date received: ___/___/___				
8. DIAGNOSIS				
Was this person diagnosed with the disease in question? <input type="checkbox"/> No <input type="checkbox"/> Unknown, why? <input type="checkbox"/> Declined medical evaluation <input type="checkbox"/> Not interviewed after incubation period <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Yes, how was diagnosis made? (Check all that apply) <input type="checkbox"/> IgM <input type="checkbox"/> Paired IgG <input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Epi-linked <input type="checkbox"/> Clinical diagnosis <input type="checkbox"/> Other, specify _____ Check any of the following potential exposures this person may have had recently for the disease in question: <input type="checkbox"/> Exposed to a confirmed case besides the index case on the ship <input type="checkbox"/> Other, specify: _____				
9. COMMENTS				

Public reporting burden of this collection of information is estimated to average 5 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 0920-0900.