

## Ebola Exposure Questionnaire for Passengers on Other Commercial Conveyances

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 develops a fever  $\geq 100.4^{\circ}$  F or other symptoms of Ebola, immediately call EOC at 770.488.7100.**

Date of initial interview: \_\_\_\_/\_\_\_\_/\_\_\_\_ Interviewed by: \_\_\_\_\_

Interviewer's Agency: \_\_\_\_\_ Interviewer's Phone Number: \_\_\_\_\_

Interviewer's Email: \_\_\_\_\_

### Passenger Information:

1. First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Country of Citizenship: \_\_\_\_\_ Country of Residence: \_\_\_\_\_

What are interviewee's travel plans through 21 days after potential exposure?:

\_\_\_\_\_

Street Address for next 21 days:

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone numbers for next 21 days: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_

What commercial conveyance was the interviewee on? : Provide complete information- including type of conveyance, date, origination city/state/country and destination city/state/country

Type of commercial conveyance: \_\_\_\_\_ Date: \_\_\_\_\_

Origination city/state/country/bus or train stop: \_\_\_\_\_

Destination city/state/country/bus or train stop: \_\_\_\_\_

Other information (e.g., bus number): \_\_\_\_\_

Location on commercial conveyance (e.g., where were you seated on bus/train or located on ship):

\_\_\_\_\_

Did interviewee move to a different seat/location?  Yes  No

If yes, which seat/location did interviewee move to? \_\_\_\_\_

Document length of time in each seat/location:

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2. Did interviewee have any interactions with sick passengers from this commercial conveyance?

Yes  No

If yes, describe this event including description of the ill passenger or their identity if known, location of the event, degree of contact (talking, touching, etc.) and length of time: \_\_\_\_\_ -

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3. Did interviewee have direct contact with blood or other body fluids (including but not limited to feces, saliva, sweat, urine, and vomit) of any passengers during the transportation mentioned above?

Yes  No (If no, skip to question 4)

If yes, describe the contact including location on the bus/train/ship of the body fluid and any other individuals involved:

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

Tears  Saliva  Respiratory secretions (cough and sneeze droplets)

Vomit  Urine  Blood  Feces  Sweat

If yes, did these fluids come in contact with the interviewee's? (Read below and check all that apply):

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 soon after this transport that the interviewee can recall when other individuals were in contact with a person's blood and/or other body fluids?

Yes  No

If yes, please describe situation and location in the bus/train/ship and/or station:

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5. Did interviewee experience any symptoms (fever, body aches, abdominal pain, diarrhea, rash, sore throat, severe headache, vomiting, weakness, unusual bruising or bleeding) since the transport with the index case on board?

Yes  No (If no, skip to question 6)

If yes, which of the following symptoms did the interviewee experience since the flight with the index case, and what were the onset date and duration of symptoms (check all that apply and list onset/duration)?

	Symptom onset (MM/DD/YY)	Duration (in days)
<input type="checkbox"/> Fever $\geq 100.4^{\circ}$ F	_____	_____
<input type="checkbox"/> Sore throat	_____	_____
<input type="checkbox"/> Body aches/muscle pain	_____	_____
<input type="checkbox"/> Severe headache	_____	_____
<input type="checkbox"/> Abdominal pain _____	_____	_____
<input type="checkbox"/> Vomiting	_____	_____
<input type="checkbox"/> Diarrhea	_____	_____
<input type="checkbox"/> Weakness	_____	_____
<input type="checkbox"/> Rash	_____	_____
Description of rash	_____	
<input type="checkbox"/> Unusual bruising or bleeding (e.g., from gums, eyes, nose)	_____	_____

6. Has interviewee travelled within the last 21 days to Sierra Leone, Guinea, Liberia, or another country experiencing widespread transmission of Ebola?  Yes  No

If yes, to which countries did the interviewee travel (check all that apply)?

Sierra Leone  Guinea  Liberia  Other

If any of the above countries are selected, please notify CDC by calling EOC at 770.488.7100.

Interviewee will need to complete additional interview with CDC SME involving in-country exposure risk.

**Classification of interviewee risk.** After the HD has completed the interview, CDC will assign a risk level and communicate follow up recommendations to the HD. **Call the EOC and ask to speak to Air Contact**

**Investigation Team after the interview to complete this process.** Refer to

<http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html> for additional information.

**Follow-up Actions (check all actions taken for this contact):**

- Active Monitoring: state or local public health authority checks with potentially exposed individual daily to assess for the presence of symptoms and fever (ie: via phone or other communication)
- Direct Active Monitoring: public health authority conducts active monitoring through direct observation
- Ebola Symptoms (fever, body aches, abdominal pain, diarrhea, rash, sore throat, severe headache, vomiting, weakness, unusual bruising or bleeding)
- Referred for medical evaluation due to presence of symptoms  
Where was (s)he referred? \_\_\_\_\_  
What was the outcome? \_\_\_\_\_  
Was (s)he tested for Ebola?  Yes  No
- Declined medical evaluation after it was recommended
- Placed under conditional release
- Placed under state issued quarantine order
- Controlled movement: exclusion from all long-distance and local public conveyances (aircraft, ship, train, bus and subway)

- Exclusion from public places (e.g., shopping centers, movie theaters), and congregate gatherings
- Exclusion from workplaces for the duration of the public health order, unless approved by the state or local health department (telework is permitted)
- Federal public health travel restrictions -[Do Not Board](http://www.cdc.gov/quarantine/quarantineisolation.html) (<http://www.cdc.gov/quarantine/quarantineisolation.html>)
- Other, please describe: \_\_\_\_\_

**Final Disposition:**

Was interviewee contacted again after the end of the 21-day incubation period?

- Yes, Date of second interview: \_\_\_\_/\_\_\_\_/\_\_\_\_  No

If yes, did interviewee develop any symptoms between the time of the flight and the end of the 21-day incubation period?  Yes  No

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

	Symptom onset (MM/DD/YY)	Duration (in days)
<input type="checkbox"/> Fever $\geq 100.4^\circ$ F	_____	_____
<input type="checkbox"/> Sore throat	_____	_____
<input type="checkbox"/> Body aches/muscle pain	_____	_____
<input type="checkbox"/> Severe headache	_____	_____
<input type="checkbox"/> Abdominal pain	_____	_____
_____		
<input type="checkbox"/> Vomiting	_____	_____
<input type="checkbox"/> Diarrhea	_____	_____
<input type="checkbox"/> Weakness	_____	_____
<input type="checkbox"/> Rash	_____	_____

Description of rash \_\_\_\_\_

Unusual bruising or bleeding \_\_\_\_\_  
(e.g., from gums, eyes, nose)

Outcome of medical evaluation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Evaluating healthcare provider name/phone number: \_\_\_\_\_/(\_\_\_\_)\_\_\_\_\_