

General Air Contact Investigation Outcome Reporting Form

FAX completed form to the CDC at [404.471.8121](tel:404.471.8121) [404.718.2158](tel:404.718.2158); For questions, call [404.639.7147](tel:404.639.7147)

1. FLIGHT INFORMATION (If more than one flight is listed, please circle the flight contact was on)				
CDC/QARS ID#	Arrival date	Departure city/airport	Arrival city/airport	Index case row
2. INDEX CASE CLINICAL AND LAB INFORMATION				
3. PASSENGER CONTACT INFORMATION				
Last name, First name	Assigned seat	Sex	DOB (mm/dd/yy)/Age (yrs)	
4. CONTACT /INTERVIEW INFORMATION				
Were you able to contact this person? <input type="checkbox"/> No, why not? <input type="checkbox"/> Incorrect locating information <input type="checkbox"/> No longer at temporary address but still in U.S. <input type="checkbox"/> Missed HD appointment <input type="checkbox"/> No response <input type="checkbox"/> Returned to country of residence <input type="checkbox"/> HD didn't attempt follow-up <input type="checkbox"/> Other, specify _____ (Stop here)				
<input type="checkbox"/> Yes, date initially 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 seat # _____ Was this person a known close contact of the index case outside of this flight (e.g. family member)? <input type="checkbox"/> No <input type="checkbox"/> Yes <u>If "Yes", date of last known exposure to index case: ___/___/___</u> When was person interviewed? <input type="checkbox"/> During incubation period <input type="checkbox"/> After incubation period <input type="checkbox"/> At both times				
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"/> No -applicable vaccine <input type="checkbox"/> Unknown				
6. HEALTH SINCE FLIGHT				
Did contact report any signs or symptoms? <input type="checkbox"/> No <input type="checkbox"/> Yes: Date of symptom onset ___/___/___ ; 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"/> No applicable prophylaxis <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 <u>person with a</u> probable or confirmed case <u>besides-other than</u> the index case on the flight <input type="checkbox"/> Other, specify _____				
9. COMMENTS				

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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.