

General Air Contact Investigation Outcome Reporting Form

FAX completed form to the CDC at 404.471.8121/EMAIL questions to airadmin@cdc.gov

1. FLIGHT INFORMATION (If more than one flight is listed, please circle the flight contact was on)				
CDC/QARS ID #	Arrival Date	Departure Airport/City	Arrival Airport/City	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 the U.S.				
<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 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				
If 'Yes', date of last known contact to index case: ____/____/____				
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"/> Does not apply <input type="checkbox"/> History of disease <input type="checkbox"/> Immunity established by serology <input type="checkbox"/> Unknown				
<input type="checkbox"/> Vaccinated Vaccination Type _____ Manufacturer _____ Date of Doses: ___/___/___; ___/___/___; ___/___/___				
6. HEALTH SINCE TRAVEL				
Did contact report any signs or symptoms? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of earliest 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"/> Unusual bleeding <input type="checkbox"/> Decreased consciousness <input type="checkbox"/> Difficulty breathing/shortness of breath <input type="checkbox"/> Neck stiffness				
<input type="checkbox"/> Recent onset of focal weakness and/or paralysis <input type="checkbox"/> Loss of Sense of smell <input type="checkbox"/> Loss of sense of taste <input type="checkbox"/> Fatigue				
<input type="checkbox"/> Other, specify _____				
7. PUBLIC HEALTH INTERVENTION				
Did contact receive prophylaxis for this exposure?				

No, why not?
 Outside window for prophylaxis
 Within window for prophylaxis but declined
 No applicable prophylaxis
 Other, specify: _____
 Yes, please indicate what s/he received and the date(s):
 Antimicrobial drug; specify _____, date received: ____ / ____ / ____
 Vaccination; date received: ____ / ____ / ____
 Immunoglobulin; date received: ____ / ____ / ____
 Other, specify _____, date received: ____ / ____ / ____

8. DIAGNOSIS

Was this person diagnosed with the disease in question?

No
 Unknown, why?
 Declined medical evaluation
 Not interviewed after incubation period
 Lost to follow-up
 Other, specify: _____
 Yes, how was diagnosis made? (Check all that apply)
 IgM
 Paired IgG
 PCR
 Culture
 Epi-linked
 Clinical diagnosis
 Other, specify _____
 Check any of the following potential exposures this person may have had recently for the disease in question:
 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.