OMB Control No. 0920-0900 Expiration Date: 5/31/2021

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 CLINI	CAL AND LAB INFORM	 ATION			
3. PASSENGER CONTACT INFORMATION					
Last name, First name		Assigned seat	Sex	DOB (mm/dd/yy)/Age(yrs)	
4 CONTACT/INTERV	IEW INFORMATION				
4. CONTACT/INTERVIEW INFORMATION					
Were you able to contact	-				
No, why not?	Incorrect locating information	100	rary address but still in the U.S.		
	No response Returned to country of residence				
	HD didn't attempt follow-up Other, specify(Stop here)				
Yes, date contacted://					
Was contact interviewed?					
No, why not? Declined Lives in different jurisdiction, specify					
Other, specify(Stop here)					
Yes; actual/verified seat #					
Was this person a known close contact of the index case outside of this flight (e.g. family member?) No Yes					
		contact to index case:/			
	When was person interviewed?	During incubation period	After incubation period	At both times	
5. IMMUNITY				1	
Vaccination or history of disease:					
☐ Not vaccinated ☐	Does not apply 🔲 Histo	ry of disease 🛮 Immunity	established by serology	☐ Unknown	
☐ Vaccinated Vaccinated	ation Type Ma	anufacturer	Date of Doses:/_/_		
6. HEALTH SINCE TRAVEL					
Did contact report any signs or symptoms? No Yes Date of earliest symptom onset/; check all that apply:					
bid contact report any signs of symptoms: a no a rest bate of earliest symptom onset, check all that apply.					
☐ Fever (Max temp measured°C/F) ☐ Cough ☐ Rash ☐ Coryza ☐ Conjunctivitis					
☐ Sore throat ☐ Swollen glands ☐ Vomiting ☐ Diarrhea ☐ Jaundice ☐ Headache					
☐ Unusual bleeding ☐ Decreased consciousness ☐ Difficulty breathing/shortness of breath ☐ Neck stiffness					
☐ Recent onset of focal weakness and/or paralysis ☐ Loss of Sense of smell ☐ Loss of sense of taste ☐ Fatigue ☐ Other, specify					
	ITED//ENTION				
7. PUBLIC HEALTH IN	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				
	ost 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.