

Land Travel Illness or Death Investigation Form
U.S. Centers for Disease Control and Prevention

Form Approved
 OMB Control No.0920-0134
 Exp XX/XX/XXXX

Section 1. Quarantine station notification

QARS Unique ID #:	CDC User ID:	Port of Entry:	State:
Person notifying CDC:		Phone:	Email:
Agency notifying CDC:		Date of initial notification to CDC: _____/_____/_____ mm dd yyyy	Time of initial notification to CDC (24 hrs): _____:_____ hh : mm
Type of notification: <input type="checkbox"/> Illness <input type="checkbox"/> Death		When was the Quarantine Station notified?:	
Type of traveler: <input type="checkbox"/> Crew <input type="checkbox"/> Passenger <input type="checkbox"/> N/A		<input type="checkbox"/> Before any travel was initiated	
Where was the traveler when the QS was notified?:		<input type="checkbox"/> During travel	
<input type="checkbox"/> In U.S. jurisdiction		<input type="checkbox"/> Prior to boarding conveyance	
<input type="checkbox"/> In foreign jurisdiction		<input type="checkbox"/> While traveler was on a conveyance	
<input type="checkbox"/> Unknown		<input type="checkbox"/> After disembarking conveyance	
		<input type="checkbox"/> After travel completed (reached final destination for that leg of trip)	
		<input type="checkbox"/> Unknown	

NOTE: If ill/deceased person also traveled via Air and/or Maritime conveyances, please fill out the appropriate form and attach

Section 2: Pertinent medical history of ill or deceased person

Relevant history: present illness, other medical problems, vaccinations, etc.:

Traveler has taken:

- Antibiotic/antiviral/antiparasitic(s) in the **past week**; list with date(s) started: _____
- Fever-reducing medications (e.g. acetaminophen, ibuprofen) in the **past 12 hrs**; list with time of last dose: _____
- Other medications (related to current symptoms/illness); list with date(s) started: _____

Relevant Exposures:

Countries visited in the past 3 weeks:	State/city/village	Arrival date	Exposure to ill persons?	Exposure to animals?	Other exposures (chemical, drug ingestion, etc)?
			<input type="checkbox"/> No <input type="checkbox"/> Yes, _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____
			<input type="checkbox"/> No <input type="checkbox"/> Yes, _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____
			<input type="checkbox"/> No <input type="checkbox"/> Yes, _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____

Signs, Symptoms, and Conditions (check all that apply) :

<input type="checkbox"/> FEVER ($\geq 100^{\circ}\text{F}$ or $\geq 38^{\circ}\text{C}$) OR feeling feverish/having chills in past 72 hrs Onset date: _____/_____/_____ Current temperature: _____ ^o F/C	<input type="checkbox"/> Sore throat Onset date: _____/_____/_____ <input type="checkbox"/> Difficulty breathing/shortness of breath Onset date: _____/_____/_____ <input type="checkbox"/> Swollen glands Onset date: _____/_____/_____ Location: <input type="checkbox"/> Head/neck <input type="checkbox"/> Armpit <input type="checkbox"/> Groin <input type="checkbox"/> Vomiting Onset date: _____/_____/_____ Number of times in past 24 hrs? _____ <input type="checkbox"/> Diarrhea Onset date: _____/_____/_____ Number of times in past 24 hrs?: _____ <input type="checkbox"/> Jaundice Onset date: _____/_____/_____ <input type="checkbox"/> Headache Onset date: _____/_____/_____ <input type="checkbox"/> Neck stiffness Onset date: _____/_____/_____ <input type="checkbox"/> Decreased consciousness Onset date: _____/_____/_____ <input type="checkbox"/> Recent onset of focal weakness and/or Paralysis Onset date: _____/_____/_____ <input type="checkbox"/> Unusual bleeding Onset date: _____/_____/_____ <input type="checkbox"/> Obviously unwell <input type="checkbox"/> Injury <input type="checkbox"/> Chronic condition <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Other: _____
<input type="checkbox"/> Rash Onset date: _____/_____/_____ Appearance: <input type="checkbox"/> Maculopapular <input type="checkbox"/> Vesicular/Pustular <input type="checkbox"/> Purpuric/Petechial <input type="checkbox"/> Scabbed <input type="checkbox"/> Other	<input type="checkbox"/> Conjunctivitis/eye redness Onset date: _____/_____/_____ <input type="checkbox"/> Coryza/runny nose Onset date: _____/_____/_____ <input type="checkbox"/> Persistent cough Onset date: _____/_____/_____ <input type="checkbox"/> With blood <input type="checkbox"/> Without blood

Deceased Persons:	Date of Death: _____/_____/_____ mm dd yyyy	Time of death (24 hours): _____:_____ hh : mm
-------------------	--	--

Presumptive Diagnosis or Cause of Death:

If traveling by conveyance, does anyone else have similar illness?: No Yes Unknown (If yes, please fill in a new form for each person in the cluster.)

Response or Report:

- Requires DGMQ Response & Follow-up (**Proceed to next section**)
- Information Report Only / No Follow-up Needed (**STOP HERE**)

Section 3. General information about the ill or deceased person

Last/paternal name:		First/given name:	
Middle name:	Maternal name (if applicable):	Other names used (e.g., former name, alias):	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth: ____/____/____ mm dd yyyy	Age (if date of birth unknown): _____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years	
Country of birth:	Frequency of border crossing: _____ times/ <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> year		
Passport country/citizenship	Type of ID:	ID document #:	Visa?: <input type="checkbox"/> Yes <input type="checkbox"/> No

For deceased persons, go to Section 5. Otherwise, continue below.

Home address:	City:	State/province:	Zip/postal code:
Country of residence:	Home telephone:	If visiting, total duration of U.S. stay: _____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years	
Contact in U.S. - Address/hotel:			E-mail:
			<input type="checkbox"/> Same as home address above
Contact in U.S. - City:	Contact in U.S. - State/territory:	Contact phone in U.S.:	
		<input type="checkbox"/> Cell Number of days reachable at contact phone: _____	
Emergency contact name:	Emergency contact relationship:	Emergency contact phone:	

Section 4. Border Crossing Information

License plate #:	State/province/country issued:	Attempted entry outside an official POE?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Contact information collected on conveyance passengers/driver(s)?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
------------------	--------------------------------	--	---

Crossing Type*	From (City/Country)	Departure date	To (City/Country)	Arrival date	Significant stops	Name of commercial carrier, if applicable	Bus/Train #	Seat #
Current Segment:								
Past & Upcoming Segments:								

*Crossing Type: **V**: Personal vehicle **TC**: Taxi cab **M**: Motorcycle **P**: Pedestrian/Bike **B**: Passenger bus **CC**: Commercial cargo vehicle **A**: Ambulance
T: Train **O**: Other

Section 5. Disposition of ill/deceased person

<p>Ill person was (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Released to continue travel <input type="checkbox"/> Advised to seek medical care <input type="checkbox"/> EMS responded <input type="checkbox"/> Recommended to not continue travel <input type="checkbox"/> Transported to hospital (<input type="checkbox"/> MOA activated): _____ <input type="checkbox"/> Transported to non-hospital location: _____ <input type="checkbox"/> Detained by law enforcement, location: _____ <input type="checkbox"/> Denied entry by law enforcement <input type="checkbox"/> Other: _____ 	<p>Deceased Person:</p> <p>Body released to medical examiner?: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Medical examiner telephone: _____</p> <p>City/State/Country: _____</p>
---	--

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 0920-0821
