

## General Aircraft Contact Investigation Outcome Reporting Form

Return completed form by secure email to [airadmin@cdc.gov](mailto:airadmin@cdc.gov) (preferred) or fax to 404-471-8121 with the following text in the SUBJECT line:  
Outcome Reporting Form DGMH ID #####

1. FLIGHT INFORMATION				
DGMH ID#	Arrival date	Departure city/airport	Arrival city/airport	Index case seat
2. INDEX CASE CLINICAL AND LAB INFORMATION				
Diagnosis: _____				
3. PASSENGER CONTACT INFORMATION				
Last name, First name	Assigned seat	Sex	DOB (mm/dd/yy)/Age (yrs)	
4. CONTACT /INTERVIEW INFORMATION				
<b>Were you able to contact this person?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If 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"/> No response <input type="checkbox"/> Returned to country of residence <input type="checkbox"/> HD didn't attempt follow-up <input type="checkbox"/> Other, specify _____ (Skip to Section 9) If yes, date initially contacted: ___/___/___				
<b>Was contact interviewed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not? <input type="checkbox"/> Declined <input type="checkbox"/> Lives in different jurisdiction, specify _____ <input type="checkbox"/> Other, specify _____ (Skip to Section 9) If 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 exposure to index case: ___/___/___				
<b>When was person interviewed?</b> <input type="checkbox"/> During incubation period <input type="checkbox"/> After incubation period <input type="checkbox"/> At both times				
5. IMMUNITY				
<b>Vaccination or history of disease:</b> <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				
<b>Did contact report any signs or symptoms?</b> <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				
<b>Did contact receive prophylaxis for this exposure?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If 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: _____ If yes, please indicate what prophylaxis was 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				
<b>Was this person diagnosed with the disease in question?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If no or 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 _____ If 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 _____ <b>Check any of the following potential exposures this person may have had recently for the disease in question:</b> <input type="checkbox"/> Exposed to a person with a probable or confirmed case <u>other than the index case on the flight</u> <input type="checkbox"/> Visited/lives in a country with high burden of disease <input type="checkbox"/> Other, specify _____				
9. FORM COMPLETION				
Person completing form: _____			Date form completed: ___/___/___	
10. 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 H21-8, Atlanta, Georgia 30333; ATTN: PRA 0920-0900.