

Traveler's Name: _____ PHARS#: _____ POE: _____

Passport Country: _____ Passport Number: _____

CDC RISK ASSESSMENT AT POE (CDC Secondary) - Marburg Response

IF TRAVELER CLINICALLY UNSTABLE: DO NOT DELAY EMS TRIAGE AND TRANSPORT. ENSURE ISOLATION, ADVANCE NOTIFICATION/PLANNING WITH STATE/LOCAL HEALTH DEPARTMENT AND RECEIVING FACILITY.

- Reason for Referral:** Symptomatic Presence in a healthcare facility
- Provided healthcare/interactions with patients (e.g., professional, trainee, student)
- Contact/near sick person (any setting) Contact with blood or other body fluids
- Contact with dead body/funeral attendance
- Other: _____

Tell traveler: "You were referred for this additional public health assessment because we need to get more specific information to complete a public health evaluation. These questions will help us decide next steps." (Be cognizant of any flight connections, or other travel).

Health Assessment (Complete if febrile/feverish, ill appearance, symptomatic on CDC Primary)

Appears well? YES NO- if NO, specify: _____

Temperature measurement in CDC Secondary: _____ (°C/°F) Method: _____

Signs/symptoms in the **past 2 days?** No symptoms reported

Fever ($\geq 100.4^{\circ}\text{F}/38.0^{\circ}\text{C}$) - if YES, T-max: _____ (C/F) Method: _____

Date (mm/dd/yy): ____ / ____ / ____ Time: _____ AM/PM (calculate using your POE's time zone)

- Subjective Fever Chills New/Unusual Fatigue New/Unusual Weakness
- New/Unusual Headache New/Unusual Muscle Pains Loss of appetite
- Cough/difficulty breathing/sore throat, other resp symptoms Chest pain
- Nausea Vomiting Diarrhea Abdominal pain Unexplained bruising/bleeding
- Skin rash [If yes, describe appearance and location(s)]: _____

Date of 1st symptom onset (mm/dd/yy): ____ / ____ / ____

Comments (include location of any pains): _____

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Use of antipyretic medication(s) in past 2 days: YES NO

(includes acetaminophen, paracetamol, aspirin, ibuprofen, systemic steroids, some cold remedies)

Public reporting burden of this collection of information is estimated to average 20 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, Reports Clearance Officer, 1600 Clifton Rd., MS H21-8, Atlanta, GA 30333, ATTN: PRA (0920-1443).

Traveler Name: _____ PHARS#: _____ POE: _____

Name of antipyretic: _____ Dose: _____ Hrs ago: _____ Purpose: _____ Name of antipyretic: _____ Dose: _____ Hrs ago: _____ Purpose: _____

Was malaria prophylaxis taken as prescribed? YES NO Name of antimalarial: _____

Complete this section if provided healthcare/interacted with patients

Was the traveler under an affiliation with a sponsoring organization? Yes No

If yes, provide name of organization: _____

Name of representative in the U.S.: _____ Phone #: _____

Does traveler have a copy of a *Predeparture Assessment Form*?

Yes No (not done) No (completed a form, even if org's own version, but traveler does not have it)

Review the form and return it to the traveler. The health department may ask them for that form. Comments:

Complete this section if any presence in healthcare facility (HCF)/healthcare setting

Healthcare facility(ies) name(s) and location(s) in Rwanda visited or worked in (check here if none visited/worked in): _____

Reason for presence in HCF/Setting (check all that apply): Patient care Clinical Lab

Cleaning/laundry Other nonclinical role (clerical, clergy, social work, meal service, administrative)

Patient Patient's companion/visitor

Present in patient care areas Present only in non-patient care areas

Other: _____

Last day present in HCF (mm/dd/yy): ____/____/____

Traditional healer visit: Yes No - If yes, describe visit: _____

Does the traveler work in a U.S. healthcare facility? Yes No

Complete this section if provided healthcare, contact/near a sick person, contact with blood/body fluids

The following questions apply to any setting (healthcare or non-healthcare):

Did you have any contact with blood/body fluids? YES NO **If NO, skip to sick person question**

Did this contact involve any of the following? Check as applicable:

Needlestick Other injury with a sharp object (that is, piercing of your skin)

Skin contact Splash to the eye, nose, or mouth

Was the person suspected or known to have Marburg?

YES SUSPECTED YES CONFIRMED UNSURE NO

Diagnosis other than Marburg, if known: _____

Description: _____

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Did you have contact with any sick person? YES UNSURE NO If NO, section is complete

Did the person have fever? YES UNSURE NO

Did the sick person have vomiting, diarrhea, or bleeding? YES UNSURE NO

Was the person suspected or known to have Marburg?

YES SUSPECTED YES CONFIRMED UNSURE NO

Diagnosis other than Marburg, if known: _____

Did you have physical contact with this person? YES NO

Did you stay in the same household as this person? YES NO

Did you provide care to this person? YES NO

If YES to provided care: Did you provide this care in a healthcare facility or another location? HCF

Home Other: _____

Comments: _____

For healthcare personnel only: What personal protective equipment did you use?

(Most relevant for care given to a patient with known or suspected MVD) No PPE

Surgical or medical mask Respirator (e.g., N95, KN95) Surgical hood PAPR

Disposable fluid-resistant or impermeable gown/coverall Disposable apron

Disposable full-face shield Goggles Waterproof rubber boots Boot covers

Latex/nitrile gloves: One pair Two pairs (outward with extended cuffs)

Other: _____

Did you perform hand hygiene after removing PPE? YES (every time) NO (not every time)

Did you experience any breach in infection control precautions?

YES UNSURE NO N/A

Did you participate in an invasive procedure or an aerosol-generating procedure?

YES UNSURE NO N/A

Comments: _____

Complete this section if worked in a clinical laboratory

Did you handle clinical specimens? YES NO

What PPE did you use? None

Surgical or medical mask Respirator (e.g., N95, KN95) Surgical hood PAPR

Disposable fluid-resistant or impermeable gown/coverall Disposable apron

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Disposable full-face shield Goggles Waterproof rubber boots Boot covers

Latex/nitrile gloves: One pair Two pairs (outward with extended cuffs)

Other: _____

Did you perform hand hygiene after removing PPE? YES (every time) NO (not every time)

Did you have a needlestick, other sharps injury (that is, piercing of your skin), or splash to the eye, nose, or mouth, or skin contact with blood or other body fluids of a person who had Marburg or may have had Marburg? YES UNSURE NO

Did you have any other contact with blood or body fluids? YES NO

Please describe: _____

Complete if worked as environmental cleaner or doing laundry in HCF

What was your role in the healthcare facility? _____

Did you perform environmental cleaning in any patient care areas? YES NO

Did you handle wet or soiled laundry? YES NO

What protective equipment did you use? None

Surgical or medical mask Respirator (e.g., N95, KN95)

Disposable fluid-resistant or impermeable gown/coverall Disposable apron

Disposable full-face shield Goggles Waterproof rubber boots Boot covers

Latex/nitrile gloves: One pair Two pairs

Other: _____

Did you wash hands after removing protective equipment? YES (every time) NO (not every time)

Did you get any body fluids on your skin or clothes? YES NO UNSURE

Comments: _____

Complete this section if reported contact with dead body or attended a funeral or burial

Did you attend a funeral or burial? YES NO Did you touch a dead body? YES NO

Please describe activities at funeral/burial or touching a dead body (touched deceased person's garments, belongings or water used to wash body?):

Was the cause of death known? YES NO If YES, please list: _____

Did you serve as mortuary/burial worker? YES NO **If NO, go to Final Open Question.**

If a mortuary/burial worker, what protective equipment (PE) did you use? None

Surgical or medical mask Respirator (e.g., N95, KN95)

Disposable fluid-resistant or impermeable gown/coverall Disposable apron

Disposable full-face shield Goggles Waterproof rubber boots Boot covers

Latex/nitrile gloves: One pair Two pairs (outward with extended cuffs)

Other: _____

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Did you wash hands after removing PE? YES (every time) NO (not every time)

Did you have any problems with your protective equipment that resulted in your skin or clothes coming into contact with the dead body or body fluids? YES UNSURE NO

FINAL OPEN QUESTION: (all travelers)

Any other situation that is of concern to you about your health that we haven't raised?
