

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
 Healthcare mission/professional/student Contact/near sick person
 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 information to determine if [select reason as appropriate based on referral]:

- you had a possible exposure to Marburg virus.
- your symptoms are concerning for Marburg disease.

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, specify: _____

Temperature measurement: _____ (°C/°F) Method: _____

Signs/symptoms in the **past 2 days?** 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 time zone of POE)

- 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): ___ / ___ / _____ No symptoms reportedComments:

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Traveler Name: _____ PHARS#: _____ POE: _____

Date of Evaluation: _____ Time: _____ AM/PM

Use of antipyretic medication(s) in past 24 hours: YES NO

Name of antipyretic: _____ Dose: _____ Time: _____ Purpose: _____

Name of antipyretic: _____ Dose: _____ Time: _____ Purpose: _____

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

SPONSORING ORGANIZATION & PREDEPARTURE ASSESSMENT AVAILABILITY

(Complete if part of healthcare mission, health personnel)

If healthcare provider or part of a healthcare mission (includes students, trainees), was the traveler under an affiliation with a sponsoring organization?

Yes No If yes, provide name of organization: _____

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

Does traveler have a copy of the *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.

HEALTHCARE FACILITY & ROLE

(Complete if any presence in healthcare facility)

Presence in Healthcare Facility:

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 (check all that apply): Patient care Laboratorian

Cleaning/laundry service Nonclinical role (clergy, social work, meal service)

Patient Patient's companion/visitor

Presence in patient care areas Presence in non-patient care areas only

Other: _____

Traditional Healer Yes No

If yes, describe visit with traditional healer: _____

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

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EXPOSURE ASSESSMENT:

(Complete if contact/near a sick person, healthcare personnel/student, blood/body fluid contact)

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

Did you stay in the same household as a person who had Marburg or may have had Marburg?

YES NO UNSURE

Did you provide care to or have other physical contact with a sick person who had Marburg or may have had Marburg?

YES NO UNSURE

Did you provide this care in a healthcare facility or another location (such as a home)?

HCF Home Other: _____

Was this sick person confirmed to have Marburg? YES NO UNSURE

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

Comments: _____

Did you have a needlestick, other injury with a sharp object (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 NO UNSURE

Any contact with blood or body fluids that I have not asked about? YES NO

[HCWs only] When you provided care for this person, what personal protective equipment did you use? N/A

Disposable fluid-resistant or impermeable gown/coverall

Disposable full-face shield Disposable facemask Boot covers Disposable apron

N95 respirator PAPR Two pairs of disposable gloves (outer gloves with extended cuffs)

[HCWs only] Did you experience any breach in infection control precautions? YES NO UNSURE N/A

[HCWs only] Did you conduct or assist with an invasive procedure on the ill person or aerosol-generating procedure? YES NO N/A

Comments: _____

CLINICAL LABORATORY:

(Complete if any work as laboratorian)

Did you handle clinical specimens? YES NO

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Date of Evaluation: _____ Time: _____ AM/PM

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 NO UNSURE

Any contact with blood or body fluids that I have not asked about? YES NO

Please describe: _____

ENVIRONMENTAL:

(Complete if any work as cleaner, custodial, or doing laundry in HC facility)

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

What PPE did you use? Disposable fluid-resistant or impermeable gown/coverall

Disposable full-face shield Disposable facemask Disposable apron

N95 respirator Disposable gloves Other: _____

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

Comments: _____

FUNERAL OR MORTUARY:

(Complete if attended a funeral or reported contact with dead body)

Please describe presence in a funeral or touching a dead body (touched deceased garments?)

Mortuary/burial worker Traditional rituals

Was the cause of death known?

If a mortuary/burial worker, what PPE did you use?

Disposable fluid-resistant or impermeable gown/coverall

Disposable full-face shield Disposable facemask Disposable apron

N95 respirator Disposable gloves Other: _____

Did you have any problems with your PPE that resulted in skin or clothes becoming contaminated?

YES NO UNSURE

Please describe any other situations/events not listed above that are of concern to the staffer/volunteer/traveler:

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SUMMARY RISK ASSESSMENT:

- Asymptomatic Symptomatic but no suspicion of MVD
 Suspect Marburg virus disease High-risk exposure to Marburg virus

Situation(s) with Additional Exposure Potential:

- Present in patient care area Provided healthcare/interacted with sick person(s)
 Received healthcare Performed clinical lab work/handled specimens
 Conducted mortuary, funerary, burial work
 Present in healthcare facility (not patient care areas such as only administrative spaces)

Presence in Rwanda (no high risk exposure or situations with additional exposure potential identified)

If any high-risk exposures are reported, or if MVD is suspected or confirmed, please do the following:

- **Quarantine/isolate the individual.**
- **If not already done as part of assessment, contact the CDC Viral Special Pathogens Epidemiologist on-call.**
- **Person may not travel commercially.**
- **Need to notify and consult with State/Local health department and facility (if applicable) for isolation/quarantine and further public health and clinical (if applicable) management.**

Date of Evaluation (mm/dd/yy): _____ Time: _____ AM/PM

Name of person performing the assessment: _____

Title: _____ Signature: _____

Name of CDC SME Consulted (if applicable): _____

ACTIONS TAKEN:

- Isolation Quarantine Federal Public Health Order No onward travel allowed
 Briefed/consulted state/local health department
 Assessment documents shared with state/local health department
 Other: _____

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ACTIONS RECOMMENDED:

- Prompt Follow up of traveler by state/local HD at destination
- Self-monitoring (all travelers with nexus to Rwanda in prior 21 days)
- Post Arrival Monitoring
- Abstain from working in either clinical or non-clinical roles in a U.S. healthcare facility until 21 days after their last presence in patient care area(s) in Rwanda healthcare facility
- Other: _____

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