**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 (≥100.4°F/38.0°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 reported

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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Use of antipyretic medication(s) in past 24 hours: ☐ YES ☐ NOName 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 ☐ NoIf 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): \_\_\_\_ /\_\_\_\_/\_\_\_\_\_

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CLINICAL LABORATORY:**   
(Complete if any work as laboratorian)  
Did you handle clinical specimens? ☐ YES ☐ NODid 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 ☐ NOWhat 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**