Form Approved OMB Control No: 0920-1443 Exp. Date: 03/31/25 Version 10/14/2024

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)*.

<u>**Health Assessment (Complete if febrile/feverish, ill appearance, symptomatic on *CDC Primary*)**</u>
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 (≥100.4°F/38.0°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):____
____
____

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).

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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: ____

<u>For healthcare personnel only</u>: 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: ____

____

<u>Complete this section if worked in a clinical laboratory</u>

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?

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