Traveler's Name: _____ PHARS#:_____

CDC RISK ASSESSMENT AT POE (*CDC Secondary*) – [SAMPLE VHF] 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 [SAMPLE VHF] virus.
- your symptoms are concerning for [SAMPLE VHF] 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: _____
_____
_

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: _____

Traveler Name: _____ PHARS#:_____

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 [COUNTRY] 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 [SAMPLE VHF] or may have had [SAMPLE VHF]?

☐ YES ☐ NO ☐ UNSURE

Did you provide care to or have other physical contact with a sick person who had [SAMPLE VHF] or may have had [SAMPLE VHF]?

☐ YES ☐ NO ☐ UNSURE

Traveler Name: _____ PHARS#:_____

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 [SAMPLE VHF]? ☐ 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 [SAMPLE VHF] or may have had [SAMPLE VHF]? ☐ 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
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 [SAMPLE VHF] or may have had [SAMPLE VHF]? ☐ 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)

Traveler Name: _____ PHARS#:_____

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:

_____

_____

SUMMARY RISK ASSESSMENT:

☐ **Asymptomatic** ☐ **Symptomatic but no suspicion of** [SAMPLE VHF]
☐ **Suspect** [SAMPLE VHF] **virus disease** ☐ **High-risk exposure to** [SAMPLE VHF] **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)

Traveler Name: _____ PHARS#:_____

☐ Presence in [COUNTRY] (no high risk exposure or situations with additional exposure potential identified)

If any high-risk exposures are reported, or if [SAMPLE VHF] 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 [COUNTRY] 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 [COUNTRY] healthcare facility**
☐ **Other:** _____