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2026 Ebola-BVD Response: FOLLOW-UP Public Health Assessment (FPHA)

For Port Health Station staff and deployers assessing travelers arriving from **DRC, Uganda, or South Sudan**

A. Administrative data				
First Name: _____ Last Name: _____ Passport #: _____ DOB: _____				
SEX: _____				
Country (DRC Province): _____ Airline: _____ Flight #: _____ Date/time of arrival: _____				
Primary purpose of travel: ☐ Tourism ☐ Work ☐ Friends/Rel. ☐ Education ☐ Volunteer ☐ Other: _____				
Traveler status: ☐ U.S. citizen/national ☐ Non-immigrant visa (i.e. crewmember or waiver) ☐ In-transit				
Date/Time (zone) START of FPHA: _____ () QARS#: _____ POE: _____ Terminal: _____				
Reason(s) for Referral	☐ Febrile/symptomatic			
	☐ Contact with dead body/burial/funeral			
	☐ Bat, monkey, ape (or remains) or mine/cave			
	☐ Present in an HCF or health-related setting			
	☐ Contact/proximity to sick person, blood, body fluids (any setting)			
	☐ Present in or transited through DRC			
B. Health Assessment			YES	NO
1. SCREENER QUESTION – Does the traveler have any obvious signs of illness (describe below)?			☐	☐
2. In the past 2 days , have you had any of the following symptoms?			☐	☐
RECHECK T-max: _____ °F Method: _____ Date: _____ Time: _____ ☐ Fever ($\geq 100.4^{\circ}\text{F}/38.0^{\circ}\text{C}$) ☐ Subjective fever ☐ Chills ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Abdominal pain ☐ Loss of appetite ☐ New/unusual fatigue ☐ New/unusual weakness ☐ New/unusual headache ☐ Unexplained bruising/bleeding ☐ New/unusual muscle pains ☐ Cough/difficulty breathing/sore throat/other respiratory symptoms ☐ Chest pain ☐ Rash ☐ Other: _____				
Date of symptom onset:	Describe all signs or symptoms (visual inspection, rash, location of pain, bleeding, etc.):			
3. Have you used fever-reducing medication, such as acetaminophen/paracetamol, aspirin, ibuprofen, steroids such as prednisone, cold remedies, in the past 2 days? <i>If YES, list medication and dose.</i>			☐	☐

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Fever-reducing medication:	Dose:	Most recent dose:
4. Were you prescribed anti-malarial medication; are/were you taking it? <i>If YES, list medication and dose.</i>		
Anti-malarial medication:	Dose:	Most recent dose:
5. Are you taking any other routine medications? <i>If YES, list medication and dose.</i>		
Routine medication:	Dose:	Most recent dose:
Routine medication:	Dose:	Most recent dose:

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C. Sponsored / Organized Travel			YES NO
1. Were you sponsored or contracted to travel by an institution or organization? <i>(If NO, skip to Section D.)</i>			☐ ☐
Organization Name and Address:			
U.S. representative	Name:	Phone:	Email:
2. Do you have a Predeparture Health Assessment Form (or equivalent) from your organization? ☐ YES, copy available ☐ YES, but copy NOT available ☐ NO, not done			
D. Contact with Sick Person / Body Fluids à IN THE PAST 21 DAYS, DID YOU:			YES NO
1. Have physical contact with any sick person with or without personal protective equipment (PPE)? <i>(If NO, skip to Section E.)</i> ☐ UNSURE			☐ ☐
If YES or UNSURE about contact with a sick person, did you have contact with:			
Any person with a fever? ☐ UNSURE			☐ ☐
Any person who was suspected of having an illness like Ebola? ☐ UNSURE			☐ ☐
If NOT an illness like Ebola, is the diagnosis known? <i>Describe in Section I.</i> ☐ UNSURE			☐ ☐
2. Come into contact with any sick person's tears, saliva, vomit, diarrhea, urine, blood, or other body fluids? If YES, what happened? ☐ Skin contact ☐ Splash to eye, nose, or mouth ☐ Needlestick ☐ Other sharp injury (piercing of skin) ☐ Other (describe in Section I below): ☐ UNSURE			☐ ☐
3. Share a household with a sick person or visited someone who was sick in their home?			☐ ☐
Did you provide any personal care to the person who was sick? <i>Describe in Section I.</i>			☐ ☐
Did you sleep in the same bed or use the same toilet as the person who was sick?			☐ ☐
E. Presence in Healthcare Facility / Health-Related Setting à IN THE PAST 21 DAYS, DID YOU:			YES NO
1. Go into, or work in or around, any healthcare facility, hospital, clinic, other health setting, traditional healer, or Ebola treatment unit? <i>If NO, skip to Question E6. If YES, also complete Section G.</i>			☐ ☐
2. Seek or receive any type of health care, accompany someone seeking care, or enter any location where health services were being conducted?			☐ ☐
3. If providing patient care, did that involve invasive procedures, surgeries, obstetrics, or aerosol-generating (intubation, bronchoscopy, pulmonary endoscopy) procedures?			☐ ☐

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4. Work in a clinical lab handling human specimens? <i>If YES, also complete Section G.</i>	☐	☐
5. Clean patient-care areas or perform laundry services in a health facility? <i>If YES, also complete Section G.</i>	☐	☐
If any YES to 1-5, describe activity and provide name(s) and location(s) where those activities occurred:		Days present in HCF:
6. Visit or work as a traditional healer?		☐ ☐
7. If not providing health care, what specific reasons were you in those locations: ☐ Patient in emergency room, surgery, stayed overnight in hospital ☐ Companion/visitor in patient-care areas ☐ Patient in outpatient clinic, community setting, laboratory, or pharmacy ☐ Visitor in non-patient areas ☐ Nonclinical role (clerical, clergy, social work, meal service, administrative) ☐ Other (describe in Section I):		
Describe additional details for Section D and Section E in Section I as needed.		

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F. Contact with Dead Body / Funeral / Burial / Mortuary Work à IN THE PAST 21 DAYS, DID YOU:		YES	NO
1. Attend a funeral or burial? <i>If YES, describe in Section I.</i>		☐	☐
2. Have contact with the body of a dead person or what appeared to be human remains or body fluids from a dead person? <i>If YES, describe in Section I.</i>		☐	☐
3. Perform mortuary work or assist in a burial? <i>If YES, also complete Section G.</i>		☐	☐
4. (If YES to questions F1, F2, or F3) Did the person have a fever prior to death? ☐ UNSURE		☐	☐
5. (If YES to questions F1, F2, or F3) What was the cause of death? <i>Specify in Section I.</i> ☐ UNKNOWN			
G. Occupational Exposures / Precautions / Biosafety Incidents à IN THE PAST 21 DAYS, DID YOU:		YES	NO
1. Come into contact with anyone suspected or confirmed to have VHF/Ebola/BVD in an HCF or other work setting mentioned above? Or any acutely ill patients who died?		☐	☐
2. Use PPE as a routine part of your work? <i>If NO use of PPE, explain in Section I.</i>		☐	☐
What types of PPE did you use?	Latex/nitrile gloves: ☐ One pair ☐ Two pairs ☐ Outer pair with extended cuffs		
	☐ Surgical mask ☐ Respirator (N95, KN95) ☐ Goggles/face shield ☐ Shoe covers		
	☐ Fluid-resistant or impermeable gown/coveralls ☐ Disposable apron ☐ Waterproof boots		
	☐ Surgical hood ☐ PAPR ☐ Other precautions (describe here):		
Did you perform hand hygiene every time after using PPE and in between patients or clients?		☐	☐
Did you experience any breaches in PPE? <i>If YES, describe in Section I.</i>		☐	☐
3. Have a needlestick, sharps injury, splash to eye/nose/mouth, or skin contact with blood/body fluids? <i>If YES, describe in Section I.</i>		☐	☐
4. Come into contact with clothing, laundry, linens, or other material or surfaces that were soiled with blood or body fluids? <i>If YES, describe in Section I.</i>		☐	☐
<i>Describe additional details for Section F and Section G in Section I as needed.</i>			
H. Certain Animal / Environmental Exposures à IN THE PAST 21 DAYS, DID YOU:		YES	NO
Come into contact with bats, monkeys, or apes (alive, apparently sick, or dead), or their body fluids, or go into a mine or cave? <i>If YES, describe circumstances and amount of time in Section I.</i>		☐	☐

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I. Additional Information Related to Other Responses

J. Open Question for All Travelers

Are there any other health concerns related to being in one of the affected countries in the last 21 days?

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K. Summary Risk Categories / Risk Assessment / Disposition		
SUSPECTED HIGH-RISK EXPOSURE OR SYMPTOMS CONSISTENT WITH VHF/EBOLA/BVD		
• Move the individual to the designated, isolated location and ensure they are supervised using proper PPE. • Notify the station Officer-in-Charge (OIC) and Senior Medical Officer • CALL CDC EOC (770)488-7100, ask to speak with Ebola Domestic Task Force on-call clinical SMEs		
L. Consultation Notes		
Brief findings and clinical summary (including coordination with health department as needed):		
PHMO review (if needed):	Names of CDC SME(s) consulted (if applicable):	FPHA end date/time:

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