Ebola Virus Disease (EVD) Consultation Form

All dates in this form should be completed in the MM/DD/YYYY format

Patient Identifier | Date: | Time:

Patient Information

Person Under Investigation (PUI) Disposition:

○ No Public Health Concern ○ Assessed Not PUI ○ PUI

Status of patient at time of case report:

○ Alive ○ Deceased ○ Unknown

If deceased, date of death

Last Name | First Name | DOB | Age

Sex:

○ Male ○ Female

Race: ☐ White/Caucasian ☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ Black / African American ☐ American Indian/Alaskan Native ☐ Unknown/Other

Ethnicity

☐ Hispanic or Latino

☐ Not Hispanic or Latino

U.S. Citizen

○ Yes ○ No ○ Unknown

Passport #

Residence:

Patient Address | City | State | ZIP Code | County | Country

Tel (cell): | Tel (work): | Tel (home): | Email address:

No. of persons at residence (including patient)

Location where patient became ill:

City: | State | If different from permanent residence, dates residing at this location -

Occupation:

☐ Child ☐ Miner (in Africa) ☐ Management/Business/Science/Arts ☐ Production/Transportation/Material Moving

☐ Student ☐ Sales/Office ☐ Hunter/Trader of African Game Meat ☐ Natural Resources/Construction/Maintenance

☐ Military ☐ Unemployed ☐ Healthcare Worker Position: Facility:

☐ Teacher ☐ Volunteer ☐ Retired ☐ Other specify:

No Public Health Concern Information

Travel History

Purpose of travel to U.S. if a non-U.S. resident

Travel (in/to/from): ☐ Guinea ☐ Liberia ☐ Sierra Leone ☐ Mali Other:

Area/Counties/Districts if known:

Dates of travel in affected countries Arrival Date in U.S.:

Interim Stop(s) and Dates (as applicable):

Airline #1 Flight #1 Date of Flight #1

Flight #1 Origin Flight #1 Destination

Airline #2 Flight #2 Date of Flight #2

Flight #2 Origin Flight #2 Destination

Additional Flight Information

Additional Travel Information

Travel in areas with known Ebola cases?

◯ Yes ◯ No ◯ Unknown If yes, describe:

Travel in rural areas

◯ Yes ◯ No ◯ Unknown If yes, describe:

Other travelers with patient:

◯ Yes ◯ No ◯ Unknown If yes, describe: [include name(s) / relationship(s)]

Symptoms developed during travel:

◯ Yes ◯ No ◯ Unknown If yes, describe

Symptoms developed while on aircraft or at the airport

◯ Yes ◯ No ◯ Unknown If yes, describe

Appropriate infection control precatutions implemented if travel and symptoms for possible Ebola virus reported (patient isolation, standard, contact, and droplet precautions):

◯ Yes ◯ No ◯ Unknown ◯ Not Applicable

Symptoms (include date of onset if a specific symptoms is known):

Date of initial symptom onset:

Fever
Yes No Unknown
Onset:
Temperature
Fahrenheit
Celsius

Vomiting/Nausea
Yes No Unknown
Onset:

Diarrhea
Yes No Unknown
Onset:

Intense Weakness/Fatigue
Yes No Unknown
Onset:

Anorexia/Loss of Appetite
Yes No Unknown
Onset:

Abdominal Pain
Yes No Unknown
Onset:

Chest Pain
Yes No Unknown
Onset:

Joint Pain
Yes No Unknown
Onset:

Headache
Yes No Unknown
Onset:

Cough
Yes No Unknown
Onset:

Difficulty Breathing/SOB
Yes No Unknown
Onset:

Difficulty Swallowing
Yes No Unknown
Onset:

Sore Throat
Yes No Unknown
Onset:

Jaundice (yellow eyes/gums/skin)
Yes No Unknown
Onset:

Red Eyes (conjunctivitis)
Yes No Unknown
Onset:

Rashes
Yes No Unknown
Onset:
Describe rash:

Symptoms continue on next page --->

Symptoms continued (include date of onset if a specific symptoms is known):

Hiccups
Yes No Unknown Onset:

Photophobia/Pain behind the eyes
Yes No Unknown Onset:

Coma/Unconscious
Yes No Unknown Onset:

Confused or Disoriented
Yes No Unknown Onset:

Unexplained bleeding from any site
Yes No Unknown Onset:

If yes, where:

Bleeding of the gums Onset:
Bleeding from injection site Onset:
Nosebleed (epistaxis) Onset:
Bloody or black stools Onset:
Fresh blood in vomit (hematemesis) Onset:
Hemoptysis Onset:
Digested blood in vomit Onset:
Bleeding from vagina (non-menstual) Onset:
Bruising of the skin (petechiae/ecchymosis) Onset:
hematuria Onset:

Any other hemorrhagic symptoms
Yes No Unknown Onset:

If yes, please provide details. If more than one other hemorrhagic symptom include onset for each symptom.

Any other symptoms not listed above:
Yes No Unknown Onset:

If yes, please provide details. If more than one other NON-hemorrhagic symptom include onset for each symptom.

Exposures of Interest: (In the 21 days prior to symptom onset)

Exposure to known or suspected Ebola patients before becoming ill:

○ Yes ○ No ○ Unknown

If yes, please complete the following for each source case: name of source case, relation to case, dates of exposure, location of exposure, *contact type*, whether the person was alive or deceased, and date of death (if applicable)

* Contact type (list all that apply):
1. Touched the body fluids of the case (blood, vomit, saliva, urine, feces)
2. Had direct physical contact with the body of the case (alive or dead)
3. Touched or shared linens, clothes, or dishes/eating utensils of the case
4. Slept, ate, or spent time in the same household or room as the case

Did patient attend a funeral before becoming ill?

○ Yes ○ No ○ Unknown

Participation in funeral (touch or carry the body):

○ Yes ○ No ○ Unknown

If yes, please complete the following for each funeral: name of deceased, relation to case, dates of funeral attendance, location of funeral, and participation in funeral

Did patient participate in disposal of human remains?

○ Yes ○ No ○ Unknown

Did patient assist in decontamination of affected areas?

○ Yes ○ No ○ Unknown

Did the patient visit anyone in a hospital before this illness?

○ Yes ○ No ○ Unknown

If yes, please complete the following: name of patient, name of facility, date of visitation, location of facility

Did patient consult a traditional/spiritual healer before illness

○ Yes ○ No ○ Unknown

Name, date, location of healer

Exposure to dead animals/"bushmeat" prepartion or consumption

○ Yes ○ No ○ Unknown

Visitation of caves inhabited by bats in country of concern

○ Yes ○ No ○ Unknown

If yes, was the animal healthy, sick, or dead?

○ Healthy ○ Sick ○ Dead

Animal exposure

☐ Bat or bat feces/urine ☐ Rodent or rodent feces/urine
☐ Primates (monkeys) ☐ Other Specify:

Health Care Worker Exposure

Are you a medical provider/care provider for ill patient

○ Yes ○ No ○ Unknown

Are you a laboratory worker

○ Yes ○ No ○ Unknown

Administrative/organization staff at facility providing care for ill patient

○ Yes ○ No ○ Unknown

Direct contact with known Ebola patients without PPE:

○ Yes ○ No ○ Unknown

Other healthcare-realated exposure(specify):

Patient Vitals

General Appearance

○ Healthy ○ Mildly Distressed ○ Toxic

O2 Saturation (%):

Blood pressure

systolic/ diastolic

Pulse

Respiration Rate:

Current patient status:

○ Deteriorating ○ Stable ○ Improving

Date and time of assessment

Laboratory Results

HGB (g/dL) HCT (%) WBC (k/mm3) Platelet count (k/mm3)

AST ALT ALP (u/L) INR APTT PT

D-Dimer Creatinine/BUN

Any abnormal findings on CBC and Chemistry Panel besides listings above:

Malaria and blood parasites smear, thick

○ Yes ○ No ○ Unknown

Thick smear interpretation:

Malaria and blood parasites smear, thin

○ Yes ○ No ○ Unknown

Thin smear interpretation:

Rapid test for malaria

○ Yes ○ No ○ Unknown

Rapid test interpretation:

Influenza testing conducted

○ Yes ○ No ○ Unknown

Test type

☐ Rapid

☐ PCR

Influenza test interpretation

Blood culture

○ Growth ○ No Growth ○ Not performed

Organism (if applicable)

Stool cultures/OP

○ Organism Identified ○ None Detected ○ Not Performed

Organism (if applicable)

Any other laboratory results (include each organism, test type, and result):

Radiographic Testing (if any):

Past Medical History

Recent Medications

Date of last antipyretic use:

Hospitalization Information and Infection Control

Admission status

○ Already admitted ○ To be admitted ○ Not to be admitted

Date of Admission

Facility name

Ward/Room

Is the patient isolated?

○ Yes ○ No ○ Unknown

Is this a private room with a private restroom?

○ Yes ○ No ○ Unknown

Conveyance used to bring patient to hospital/clinic

○ POV ○ Ambulance ○ Medevac ○ Aircraft ○ Other Specify:

Name, date and time, and type (e.g. outpatient clinic, emergency room) of locations WITHIN this facility visited while symptoma

Seen for same symptoms prior to being seen/admitted (e.g. another medical facility/provider)

○ Yes ○ No ○ Unknown

Was the patient isolated at each facility?

○ Yes ○ No ○ Unknown

If yes, please complete a line of information for each location including: Dates of Hospitalization, Health Facility Name, City, State, and Isolation Status.

Infection control procedures in place (check all that apply):

☐ Contact ☐ Droplet ☐ Airborne ☐ Standard ☐ None of these

When were procedures put in place:

○ Upon arrival ○ Other:
○ after __ hours/mins ○ Unknown
○ after __ days

Value for when procedures put in place

PPE required for entering room (check all that apply):

☐ Gowns ☐ Gloves ☐ Eye protection ☐ Facemask ☐ Goggles Other, please list:

Have any aerosol generating procedures (e.g. bronchoscopy, CPE, intubations, etc.) been performed on the patient?

○ Yes ○ No ○ Unknown

List procedures and date they were performed:

Has any personnel had unprotected exposures to the patient?

○ Yes ○ No ○ Unknown

Describe any unprotected exposures:

Were laboratory workers using CDC recommended precautions (http://www.cdc.gov/vhf/ebola/hcp/interim-3guidance-specimen-collection-submission-patients-suspected-infection-ebola.html)?

○ Yes ○ No ○ Unknown

Describe any break in precautions

Clinical Specimens and Laboratory Testing

Has this patient had a sample submitted previously for EVD testing

○ Yes ○ No ○ Unknown

Sample collection date:

Testing Facility

Date sample tested

Test Result

○ Pos ○ Neg ○ Inc ○ Inadequate ○ N/A

Current Sample

Status of patient at current sample collection

○ Alive ○ Deceased ○ Unknown

Submitting Facility

City

State

Contact Name

Sample 1:

Sample collection date

Sample type

○ Whole blood
○ Skin biopsy
○ Post-mortem heart blood
○ Other specimen

specify other:

Testing facility

telephone #

Date of test result

Test Result

○ Pos ○ Neg
○ Inc ○ Inadequate
○ N/A

Sample 2:

Sample collection date

Sample type

○ Whole blood
○ Skin biopsy
○ Post-mortem heart blood
○ Other specimen

specify other:

Testing facility

telephone #

Date of test result

Test Result

○ Pos ○ Neg
○ Inc ○ Inadequate
○ N/A

Patient Outcome Information

Date outcome information completed

Final Status of Patient

○ Alive ○ Deceased ○ Unknown

If the patient has recovered and been discharged from the hospital:

Facility name of discharge City State

Date of discharge Date of discharge from isolation (if applicable)

If the patient is deceased:

Date of death City State

Location at time of death:

○ Home
○ Hospital — Facility name
○ Emergency Department — Facility name
○ Outpatient Clinic — Facility name
○ Other specify:

Was an autopsy or other medical examination performed on the body

○ Yes ○ No ○ Unknown

What was the final disposition of the body

○ Burial ○ Cremation ○ Unknown

Cremation: Date of cremation

Cremation Facility Name

City State

Burial: Date of funeral/burial

Funeral Facility Name

City State

Was body prepared for funeral (washed, embalmed, etc.)

○ Yes ○ No ○ Unknown

Place of burial:

City State

Reporting

Case discussed with county health department (CHD)?

○ Yes ○ No ○ Unknown

CHD:

Name of CHD contact: Best Contact Number:

Consultation Form Submitted By:

Name: Title:

Email: Fax: Alternate number

Alternate Point of Contact (POC) Name: Alternate POC Number

Laboratory Results

HGB (g/dL) | HCT (%) | WBC (k/mm3) | Platelet count (k/mm3)

AST | ALT | ALP (u/L) | INR | APTT | PT

D-Dimer | Creatinine/BUN

Any abnormal findings on CBC and Chemistry Panel besides listings above:

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Thick smear interpretation:

Influenza testing conducted

○ Yes ○ No ○ Unknown

Test type

☐ Rapid

☐ PCR

Influenza test interpretation

Any other laboratory results (include each organism, test type, and result):

Radiographic Testing (if any):

Past Medical History