### Ebola Virus Disease (EVD) Consultation Form

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

#### Patient Information

<table>
<thead>
<tr>
<th>Patient Identifier</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

#### 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: [ ]

- 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

- Address:
  - Patient Address: [ ]
  - City: [ ]
  - State: [ ]
  - ZIP Code: [ ]
  - County: [ ]

- Telephone:
  - (cell): [ ]
  - (work): [ ]
  - (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
  - [ ] Other specify: [ ]

- No Public Health Concern Information:
  - [ ]
  - [ ]
  - [ ]

[ ]
<table>
<thead>
<tr>
<th>Purpose of travel to U.S. if a non-U.S. resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel (in/to/from): [ ] Guinea [ ] Liberia [ ] Sierra Leone [ ] Mali [ ] Other:</td>
</tr>
<tr>
<td>Area/Countries/Districts if known:</td>
</tr>
<tr>
<td>Dates of travel in affected countries:</td>
</tr>
<tr>
<td>Interim Stop(s) and Dates (as applicable):</td>
</tr>
<tr>
<td>Airline #1</td>
</tr>
<tr>
<td>Flight #1 Origin</td>
</tr>
<tr>
<td>Airline #2</td>
</tr>
<tr>
<td>Flight #2 Origin</td>
</tr>
</tbody>
</table>

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:

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 precautions implemented if travel and symptoms for possible Ebola virus reported (patient isolation, standard, contact, and droplet precautions):
- [ ] Yes
- [ ] No
- [ ] Unknown
- [ ] Not Applicable
### Symptom Details

#### Date of Initial Symptom Onset:

- **Fever**
  - Onset:
  - Temperature: [ ] Fahrenheit [ ] Celsius

- **Vomiting/Nausea**
  - Onset:

- **Diarrhea**
  - Onset:

- **Intense Weakness/Fatigue**
  - Onset:

- **Anorexia/Loss of Appetite**
  - Onset:

- **Abdominal Pain**
  - Onset:

- **Chest Pain**
  - Onset:

- **Joint Pain**
  - Onset:

- **Headache**
  - Onset:

- **Cough**
  - Onset:

- **Difficulty Breathing/SOB**
  - Onset:

- **Difficulty Swallowing**
  - Onset:

- **Sore Throat**
  - Onset:

- **Jaundice (yellow eyes/gums/skin)**
  - Onset:

- **Red Eyes (conjunctivitis)**
  - Onset:

- **Rashes**
  - Onset:
  - Describe rash:

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*Symptoms continue on next page...*
Symptoms continued (include date of onset if a specific symptoms is known):

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
<th>Onset:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hiccups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Photophobia/Pain behind the eyes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coma/Unconscious</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confused or Disoriented</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unexplained bleeding from any site</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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-menstrual): Onset: |
- Bruising of the skin (petechiae/ecchymosis): Onset: |
- Hematuria: Onset: |

Any other hemorrhagic symptoms: 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. 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" preparation 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-related 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 symptomatic:

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
- 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:

Describe any unprotected exposures:

Were laboratory workers using CDC recommended precautions (http://www.cdc.gov/vhf/ebola/hcp/interim-3-guidance-specimen-collection-submission-patients-suspected-infection-ebola.html)?
- Yes
- No
- Unknown

Describe any break in precautions
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
- [ ] Emergency Department
- [ ] Outpatient Clinic
- [ ] Other specify: 
  - Facility name: 
  - City: 
  - State: 

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**: 
  - 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

**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**: 

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Laboratory Results

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Test type
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PCR

Influenza test interpretation

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Past Medical History