

Ebola Virus Disease (EVD) Consultation Form

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

Patient Identifier
Patient Information

Date:

Time:

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:

Travel History

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

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

Area/Countries/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 precautions 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 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" 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 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-3-guidance-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

Contact Number

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

Facility name

Facility name

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

Burial: Date of funeral/burial

Cremation Facility Name

Funeral Facility Name

City State

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