EBOLA CASE REPORT FORM

Please return to: Centers for Disease Control and Prevention, Viral Special Pathogens Branch
Ph: (470) 312-0094 Fax: (404) 471-2526 Email: spather@cdc.gov

INSTRUCTIONS: For the purposes of this form, Ebola refers to the disease in humans caused by ebolaviruses, including Ebola virus (*Zaire ebolavirus*), Sudan virus (*Sudan ebolavirus*), Bundibugyo virus (*Bundibugyo ebolavirus*), and Tai Forest virus (*Taï Forest ebolavirus*). Please complete this form in as much detail as possible for confirmed Ebola cases. **Please record all dates as mm/dd/yyyy.**

VSPB EPI-NUMBER *(assigned by CDC)*: ______ **STATE/LOCAL ID:** ______ **DGMQ ID:** ______

I. CASE IDENTIFICATION

State Health Department reporting case: ______ **Date form completed** *(mm/dd/yyyy)*: ______

Person completing Report: ______ **Email:** ______ **Phone number:** ______

Name of patient's physician: ______ **Email:** ______ **Phone number:** ______

How was the case identified? *Mark all that apply.*

- CDC Airport Public Health Risk Assessment
- Public Health Monitoring via State/ Local HD
- Presented to Emergency Department/Hospital/Outpatient Clinic
- Other, Specify: ______

Current case classification: Confirmed Ebola case   Suspect Ebola case   Not an Ebola case

See NNDSS National Case Definition: [Viral Hemorrhagic Fever (VHF) 2022 Case Definition | CDC]

II. CASE DEMOGRAPHIC AND CONTACT INFORMATION

Sex:
- Male
- Female
- Unknown

Birthdate: ______
or Age: ______

Race (check all that apply):
- American Indian/Alaska Native
- Black or African American
- Asian
- Native Hawaiian/other Pacific Islander
- White
- Other: ______

Ethnicity: Hispanic or Latino   Non-Hispanic or Latino   Unknown   Other: ______

Is the patient a resident of the United States? Yes   No

If *YES*, where is the patient's U.S. residence? **State:** ______ **County (Provide FIPS code):** ______

If *NO*, where is the patient's non-U.S. Residence?

Country: ______ **District/County:** ______

City: ______

Occupational Information

What kind of work does the patient do? *(for example, registered nurse, janitor, flight attendant)*? ______

What kind of business or industry does the patient work in? *(for example, hospital, clinic, airline)*? ______

III. CLINICAL HISTORY

Date of symptom onset (mm/dd/yyyy): ______

Where was the patient when their symptoms first began?

Country: ______ **State (if in the US):** ______

District/county: ______ **City:** ______

Has the patient experienced new onset of any of the following?

Symptom	Date symptom began		
Fever (Measured)> 38°C/100.4° Temp: C/F	Date symptom began: ______	**or**	Unknown
Fever (subjective) or chills	Date symptom began: ______	**or**	Unknown
Fatigue	Date symptom began: ______	**or**	Unknown
Headache	Date symptom began: ______	**or**	Unknown
Stomach Pain	Date symptom began: ______	**or**	Unknown
Joint pain	Date symptom began: ______	**or**	Unknown
Muscle Pain	Date symptom began: ______	**or**	Unknown
Diarrhea	Date symptom began: ______	**or**	Unknown
Conjunctivitis (red eyes)	Date symptom began: ______	**or**	Unknown
Rash	Date symptom began: ______	**or**	Unknown

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Has the patient experienced new onset of any of the following?

Anorexia/loss of appetite	Date symptom began: ________	or	Unknown
Sore throat	Date symptom began: ________	or	Unknown
Seizures	Date symptom began: ________	or	Unknown
Chest pain	Date symptom began: ________	or	Unknown
Shortness of breath	Date symptom began: ________	or	Unknown
Nausea/Vomiting	Date symptom began: ________	or	Unknown
Unexplained Bruising/Bleeding	Date symptom began: ________	or	Unknown

If *YES*,

- Ecchymoses (bruising)
- Epistaxis (nose bleed)
- Hemoptysis (coughing blood)
- Hematemesis (vomiting blood)
- Hematochezia (blood in stool)
- Gingival hemorrhage
- Injection site hemorrhage
- Vaginal bleeding (non-menstrual)
- Other bleeding *(specify)*: ____________

Hiccups	Date symptom began: ________	or	Unknown
Other, please specify: ____________	Date symptom began: ________	or	Unknown

Is patient pregnant?
Yes
No
Unknown

If *YES*,
How many weeks/months pregnant?
________ weeks months

Is patient breastfeeding?
Yes
No
Unknown

Has malaria testing been performed?
Yes
No
Unknown

If *YES*, type of Malaria test:
RDT
Smear
Other, specify: ____________

Malaria test result:
Positive
Negative
Pending

If positive, what species was detected?
P. falciparum
P. vivax
P. malariae
P. ovale
Unknown

Significant results of laboratory or other diagnostic testing?

Did patient die from this illness or complications of this illness?
Yes
No
Unknown

If *DECEASED*:
Date of Death: ________ **City:** ____________ **State:** ________
Was an autopsy or other medical examination performed on the body?
Yes No Unknown **If *YES*, Date of autopsy/medical examination):** ________

What was the final disposition of the body?
Cremation, date: ________
Burial, date of funeral/burial: ________
Unknown

VSPB EPI-NUMBER *(assigned by CDC)*: ______ STATE/LOCAL ID: ______ DGMQ ID: ______

IV. HOSPITALIZATION(S) DURING ILLNESS

Was patient hospitalized because of this event? Yes No Unknown

Fill out table below for each facility where the patient was seen. If patient is currently hospitalized, leave discharge date blank.

Dates of hospitalization	Health Facility Information	How was the patient transported to the health facility	Was the patient managed under isolation precautions?	If isolated, describe *(mark all that apply)*
Admission: ______ **Discharge:** ______	**Health Facility Name:** ______ **City:** ______ **State:** ______	Ambulance /EMS Personal vehicle Other, specify:	Yes - **Date of isolation:** ______ No Unknown	Single room Contact precautions Droplet precautions Airborne precautions Other, specify:
Admission: ______ **Discharge:** ______	**Health Facility Name:** ______ **City:** ______ **State:** ______	Ambulance /EMS Personal vehicle Other, specify:	Yes - **Date of isolation:** ______ No Unknown	Single room Contact precautions Droplet precautions Airborne precautions Other, specify:

Additional case details/comments:

V. TRAVEL HISTORY AND EPIDEMIOLOGICAL RISK FACTORS PRIOR TO ILLNESS

Did the patient travel to an Ebola-affected country/region in the 3 weeks before becoming ill? Outbreaks | Ebola (Ebola Virus Disease) | CDC

Yes No Unknown

If *YES*, where?

Country: ______ **District/County:** ______

City: ______ **Dates of visit:** From: ______ to: ______

Nature of travel?

- Residence
- Business
- Visiting friends and relatives (VFR)
- Tourism
- Medical/relief response *(e.g., worked in laboratory, provided care, provided disaster relief, etc.)*, specify organization: ______
- Other: ______

Has the patient had contact with a symptomatic Ebola case (suspect or confirmed), or Ebola survivor in the 3 weeks before becoming ill?

Yes, confirmed Ebola case Yes, suspect Ebola case Yes, Ebola survivor No Unknown

If *YES*, dates of contact: ______ to ______

Nature of contact with the suspect or confirmed case *(mark all that apply)***:**

- Healthcare worker wearing appropriate PPE (no direct contact with blood or body fluids)
- Direct contact with blood or body fluids of a symptomatic Ebola case
- Contact with surfaces, linens, or other items of a symptomatic Ebola case
- Sexual contact with a symptomatic Ebola case or Ebola survivor
- Direct contact with body of individual who died of Ebola
- Household or other contact (lived in close proximity without direct contact)
- Other: ______

Did the patient care for someone who was sick or died while in an Ebola-affected country/region in the 3 weeks before becoming ill?

Yes No Unknown

If *YES*, dates of contact: ______ to ______

Nature of contact with the ill person *(mark all that apply)***:**

- Healthcare worker wearing appropriate PPE (no direct contact with blood or body fluids)
- Direct contact with blood or body fluids
- Contact with surfaces, linens, or other items the ill person had touched
- Sexual contact with an ill person
- Direct contact with body of individual who died
- Household or other contact (lived in close proximity without direct contact)
- Other: ______

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Did the patient visit a healthcare facility or traditional healer (witch doctor) while in an Ebola-affected country/region in the three weeks before becoming ill?
Yes No Unknown

If *YES*, fill out the table below for each facility:

Name of healthcare facility	Location	Date Arrived	Date Departed	Purpose of visit
	Country: ____ **District/County:** ____ **City:** ____	____	____	Healthcare provider Healthcare (for self) Healthcare (for family/friend) Other: ____
	Country: ____ **District/County:** ____ **City:** ____	____	____	Healthcare provider Healthcare (for self) Healthcare (for family/friend) Other: ____
	Country: ____ **District/County:** ____ **City:** ____	____	____	Healthcare provider Healthcare (for self) Healthcare (for family/friend) Other: ____
	Country: ____ **District/County:** ____ **City:** ____	____	____	Healthcare provider Healthcare (for self) Healthcare (for family/friend) Other: ____

Did the patient attend a funeral in an Ebola-affected country/region in the 3 weeks before becoming ill?
Yes No Unknown

If *YES*, where was the funeral?

Country: ____________ **District/County:** ____________

City: ____________ **Dates of the funeral:** ________ to ________

Did the patient participate in burial practices (touch the body, wash the body, wash clothes of the deceased)?
Yes No Unknown

Did the patient have any animal contact in an Ebola-affected country/region in the 3 weeks before becoming ill?
Yes No Unknown

If *YES*, what species of animal *(check all that apply)***?**
Bat
Non-human primate (monkey)
Other, specify: ____________

Dates of contact:

From: ________

To: ________

Nature of contact with the animal: ____________

Did the animal display any symptoms of illness or was the animal dead?
Yes No Unknown

Did the patient consume any meat harvested from wild animals in an Ebola-affected country/region in the 3 weeks before becoming ill?
Yes
No
Unknown

If *YES*, Date of last contact: ________

Specify type of animal:
Bat
Non-human primate (monkey)
Other, specify: ____________

Did the patient work or spend time in a mine/cave in an Ebola-affected country/region in the 3 weeks before becoming ill?
Yes
No
Unknown

If *YES*, location?
Country: ____________
District/County: ____________

Date of last contact: ________

VI. EBOLAVIRUS LABORATORY TESTING – *For Confirmed Cases Only*

Where did the patient's sample test positive for ebolavirus? (*mark all that apply*)
- Non-CDC Laboratory
- CDC Laboratory

Non-CDC Laboratory Testing

Originating Facility: ____________ **City:** ____________ **State:** ____________

Point of Contact: ____________ **Phone Number:** ____________ **E-mail:** ____________

Where was the testing performed?
- Laboratory Response Network Laboratory
- Regional Special Pathogens Treatment Center Laboratory
- Other, specify: ____________

Where is the Laboratory located? ____________ **Specimen ID:** ____________

Test Performed (ex. Biofire): ____________

Date of specimen collection: ____________ **Date the test was performed:** ____________

Test Result:
- Positive
- Negative
- Other, specify: ____________

CDC Laboratory Testing

Originating Facility: ____________ **City:** ____________ **State:** ____________

Point of Contact: ____________ **Phone Number:** ____________ **E-mail:** ____________

Specimen ID: ____________

Test Performed: *Zaire ebolavirus* *Sudan ebolavirus*

Date of specimen collection: ____________ **Date the test was performed:** ____________

Test Result:
- Positive
- Negative
- Other, specify: ____________

ADDITIONAL INFORMATION