

Screening Form for Evaluation and Testing for Ebola Virus Disease

In the past 21 days has the person:	NO	YES
Traveled to, or been resident in, an affected area? (http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html)	<input type="checkbox"/>	<input type="checkbox"/>
Had any contact with an individual with known or suspected Ebola virus disease (EVD)?	<input type="checkbox"/>	<input type="checkbox"/>
If NO to both questions, STOP - no further action is required.		↓
If yes to either of these questions, proceed to questions below.		↓

I. PATIENT AND REPORTER INFORMATION

Date/Time:		Interviewer:	
Interviewer Contact	Office:	Cell:	
Is this person currently being monitored as a contact or traveler? Yes No		If Yes, Maven ID:	
Reporter Name:		Reporter Phone:	
Physician Name:		Physician Phone:	
Facility:			
Patient Name	First:	Last:	
Patient Address		Town:	State/Zip:
Patient Phone	Home:	Work:	Cell:
Date of Birth: / /	Age:		Sex: M F
Race:	American Indian/Alaska Native	Asian	Black/African-American
	Native Hawaiian/Pacific Islander	White	Other _____
Ethnicity:		Hispanic/Latino	
		Non-Hispanic/Latino	
Occupation:	Workplace and address:		
US Citizen? Yes No If no, permanent US resident? Yes No If no, Country of Residence:			
Country(s) Visited or lived:			
Date of arrival in [country(s)]? / /			
Date left Country: / /		Date of arrival in US: / /	
Locations visited in [country(s)]:			
Purpose of travel to [country(s)]? Resident of Country Visiting friends/family Tourism			
Work, type of work: Healthcare Humanitarian Aid – not Healthcare Related			
Journalist/Photographer/Related field Other (specify):			
Other (specify):			

III. CLINICAL ASSESSMENT

	NO	YES
Does person have symptoms of fever (subjective or $\geq 100.4^{\circ}\text{F}$ or 38.0°C) OR headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain or hemorrhage?		
IF YES, complete Present Illness Questions		↓

PRESENT ILLNESS		Onset Date: / /			
Symptoms (check all that apply) Fever ($\geq 100.4^{\circ}\text{F}$ / 38°C): Highest: _____ Headache (severe) Abdominal Pain Diarrhea		Vomiting Muscle pain (myalgia) Hemorrhage (specify location) Joint pain Weakness Anorexia Red eyes		Rash (specify type/location) Hiccups Cough Chest pain Difficulty breathing Difficulty swallowing Other	
Hospitalized? YES NO		Hospital name			Medical Record number
Admit date / /	Discharge date / /	Discharge Diagnosis	In ER?	In ICU?	Patient room number(s)
Current Disposition? In ED Admitted Died Recovered Unknown If Died, date died: _____					
Malaria Prophylaxis while traveling? Yes No Unknown			Yellow Fever Prophylaxis while traveling? Yes No Unknown		
Did patient have any illnesses while traveling? If yes, describe:			Medications taken while traveling:		

LABORATORY INFORMATION

Test type	Test Performed?	Collection Date	Result			
Blood Culture	Yes No Unk					
Malaria Smear	Yes No Unk					
CBC/Other blood test	Yes No Unk		WBC	Hgb/Hct	Plat	PT/PTT
Liver function	Yes No Unk		ALT (SGPT)		AST (SGOT)	
Renal Function	Yes No Unk		Creatinine		BUN	
Specify other abnormal findings						
Specimen sent for Ebola testing? No Yes: PCR Ab Virus isolation EIA Tissue for IHC Other _____						
Specimen tracking number:			Date/Time shipped:			

IV. INFECTION CONTROL

Patient arrived at facility by:	Personal vehicle	Ambulance	Medevac-Aircraft	Other
Is patient isolated in private room with private restroom?	Yes	No		
Infection Control procedures in place (check all that apply):	Contact	Droplet	Airborne	Standard
When were Infection Control procedures put in place?	Upon arrival	After ___ hours	After ___ days	
Other: _____				
Have any aerosol generating procedures been performed?	Yes	No	Unknown	
If yes, describe:				
Have any personnel had unprotected (without PPE) exposure to the patient?	Yes	No	Unknown	
If yes, describe:				
Is there a log for staff/visitors entering and exiting room?	Yes	No		
Was patient seen with same symptoms prior to current visit?	Yes	No		
If yes, date seen: / /	Facility:			