Viral Hemorrhagic Fever

Agency:

Investigator: Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name: First and middle name: Maiden name: Suffix: Address line: Zip: City: State: County: Phone: ( )- - Type: Long-term care resident: ☐ Yes ☐ No ☐ Unknown Facility name:

Date of Birth: / / Estimated? ☐ Age:

Gender: ☐ Female ☐ Male ☐ Other

Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed

Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Parent/Guardian name:

Parent/Guardian phone: ( )- - Type:

EVENT

Diagnosis date: / / Onset date: / /

Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown

Outbreak related: ☐ Yes ☐ No ☐ Unknown

Outbreak name:

Exposure setting:

Epi-linked: ☐ Yes ☐ No ☐ Unknown

Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown

State: Country:

Healthcare provider information

Last name:

First name:

Provider time: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA

Facility name:

Address line 1:

Address line 2:

Zip code: City:

State: County:

Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /

Date received: / / Specimen source: Test type:

Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative

Organism: Type (e.g. serotype):

Laboratory: Accession #: Collection date: / /

Date received: / / Specimen source: Test type:

Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative

Organism: Type (e.g. serotype):

Laboratory: Accession #: Collection date: / /

Date received: / / Specimen source: Test type:

Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative

Organism: Type (e.g. serotype):

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____ Job title: _____
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____
Date worked from: / / Address: _____
Date worked to: / / Zip code: _____
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____
Date removed: / / Phone: ( )- - Type: _____
Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Occupation type: _____ Job title: _____
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____
Date worked from: / / Address: _____
Date worked to: / / Zip code: _____
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____
Date removed: / / Phone: ( )- - Type: _____
Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____
Admission date: / / Discharge date: / / Days hospitalized: _____
Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Symptoms:
☐ Diarrhea ☐ Fever ☐ Headache ☐ Maculopapular rash ☐ Malaise ☐ Muscle pain ☐ Renal failure ☐ Shock ☐ Sore throat ☐ Vomiting

OTHER LAB FINDINGS

Thrombocytopenia: ☐ Yes ☐ No ☐ Unknown **Lymphopenia:** ☐ Yes ☐ No ☐ Unknown

TREATMENT

Antivirals prescribed: ☐ Yes ☐ No ☐ Unknown

Antiviral: _____
Date started: / /
Dose: _____
Unit: ☐ mg ☐ ml ☐ IU # of days: _____
# of times a day: _____ Route: _____

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Dose: _____
Unit: ☐ mg ☐ ml ☐ IU # of days: _____
# of times a day: _____ Route: _____

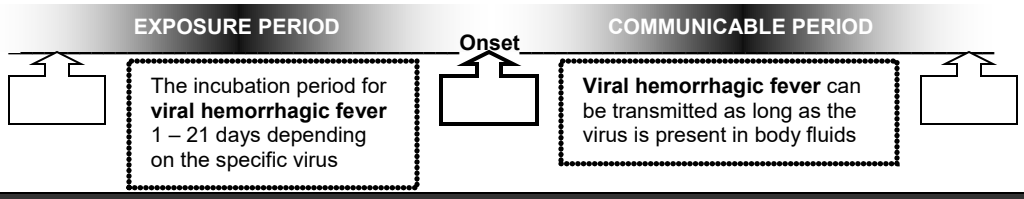
Therapeutic medications prescribed? ☐ Yes ☐ No ☐ Unk

List medications: _____

_____

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Risk Factors/Travel Information – *In the 1 to 21 days prior to onset of symptoms did the case consume the following:*

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk — City in Iowa: _____ — Departure date: ___/___/___ — Return date: ___/___/___

Traveled within U.S.? ☐ Yes ☐ No ☐ Unk — State: _____ City: _____ — Departure date: ___/___/___ — Return date: ___/___/___

Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk — Country: _____ — Departure date: ___/___/___ — Return date: ___/___/___

Exposures – *In the 1 to 21 days prior to the onset of symptoms did the case have the following exposures:*

Animal contact: ☐ Yes ☐ No ☐ Unk — Animal: ☐ Chimpanzees ☐ Forest duikers ☐ Gorillas ☐ Monkeys

Exposed to potential infection sources: ☐ Yes ☐ No ☐ Unk — Possible VHF sources: ☐ Injected drugs ☐ Needle stick ☐ Contact with blood or other body fluids ☐ Contact with deceased person

NOTES: _____