



EBOLA VIRUS DISEASE SCREENING FORM

Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212
Los Angeles, CA 90012
213-240-7941 (phone), 213-482-4856 (facsimile)
publichealth.lacounty.gov/acd/

Did the patient travel to Ebola Virus Disease (EVD) Affected Areas (Guinea, Liberia, and Sierra Leone**)?

OR

Did the patient have contact with an individual with known or suspected EVD disease?

If any checked above, COMPLETE the remainder of this form. If unchecked, STOP here and evaluate for other illnesses.

Interviewer Name: _____ Interviewer Phone:(_____) _____ Interview Date/Time: _____

Reporter Name: _____ Reporter Phone:(_____) _____ Facility Name: _____

Physician Name: _____ Physician Phone:(_____) _____ Physician Pager:(_____) _____

Infection Preventionist Name: _____ Infection Preventionist Phone:(_____) _____

Was the patient interviewed? Yes No If No, Specify proxy name(s), relationship(s) to patient: _____

Proxy Phone:(_____) _____ Emergency Contact/Phone: _____

Patient Name-Last	First	Middle Initial	Date of birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Address- Number, Street, Apt #	City	State	ZIP Code
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Telephone number Home (_____) _____	Work (_____) _____	Cell (_____) _____
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Race (check one): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____	Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino
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Country of Residence	Occupation
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Occupation setting: Childcare/School Food Service Health Care Laboratory Other Residential Facility
 Institution (Correctional Facility, Drug Treatment Center, Homeless Shelter, Military Facility) Other. _____

PRESENT ILLNESS

Onset date	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital name	Medical record number
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Admit date	Discharge date (if applicable)	Discharge Diagnosis	In ER? <input type="checkbox"/> Yes <input type="checkbox"/> No	In ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient room number(s)
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Symptoms (check all that apply):

<input type="checkbox"/> Fever (≥ 100.4° F/38° C): Highest _____	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Headache (severe)	<input type="checkbox"/> Weakness/Fatigue	<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Lack of appetite (anorexia)	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Red eyes	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Rash: Specify type. _____ Specify location. _____	Specify. _____
<input type="checkbox"/> Muscle pain (myalgia)	<input type="checkbox"/> Hiccups	
<input type="checkbox"/> Hemorrhage: <input type="checkbox"/> Eyes <input type="checkbox"/> Nose <input type="checkbox"/> GI tract	<input type="checkbox"/> Cough	
<input type="checkbox"/> Other: Specify site. _____		

Current Disposition? In ED Admitted Died Recovered Unknown If Died, Date died: _____

Malaria Prophylaxis Yes No Unknown Yellow Fever Prophylaxis Yes No Unknown

LABORATORY INFORMATION

Test type	Test performed?	Collection Date	Result
Blood culture	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Malaria smear	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
CBC/other blood test	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		WBC (c/uL) Hgb/Hct (mg/dL) Platelets (<150,000) PT/PTT
Liver function	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		ALT (SGPT) AST (SGOT)
Renal function	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Creatinine BUN

Specify other abnormal laboratory findings.

Patient name (last, first) _____ Date of Birth _____

EPIDEMIOLOGIC RISK FACTORS (within the past 21 days before the onset)

Did the person travel to the Ebola Virus Disease (EVD) Affected Areas (Guinea, Liberia, and Sierra Leone**)? Yes No Unk

If Yes, Last date in the Ebola Virus Disease (EVD) Affected Area(s)? ____/____/____

Affected Area(s) visited: Guinea Liberia Sierra Leone

Reason for travel: Business Vacation Visiting family Permanent residence Ebola-response activities: Agency _____

Other: _____

Specify the person's travel itinerary to and/or from the Affected Area(s) below.

Departure from (Country, City/Region)	Departure Date	Destination (Country, City/Region)	Arrival Date	Airline	Flight No.

Was the person near anyone who was sick with EVD symptoms (signs of fever, vomiting, diarrhea, OR unexplained bleeding)? Yes No Unknown

If Yes, Explain. _____

Did the person visit or work in a healthcare facility or other healthcare setting in the Affected Areas**? Yes No Unknown

If Yes, Specify facility/setting. _____

Nature of visit/work: _____

Were there any patients with EVD at that facility/setting? Yes No Unknown

Did the person have direct contact with a known EVD patient? Yes No Unknown

If Yes, Specify date(s) of exposure. _____

Type of contact

Provision of medical care to EVD patient? Yes No Unknown

If Yes, Was Personal Protective Equipment (PPE) worn? Yes No Unknown

Laboratory work associated with an EVD patient? Yes No Unknown

If Yes, Was Personal Protective Equipment worn? Yes No Unknown

Any percutaneous(needle stick) or mucous membrane exposure(splashes to eyes/nose/mouth) to body fluids from EVD patient? Yes No Unk

Did the person have close contact# with EVD patients in healthcare facilities in Affected Areas**? Yes No Unknown

If Yes, Specify type of contact. _____

Did the person attend or participate in a funeral for an EVD patient? Yes No Unknown

If Yes, Was there direct exposure to the human remains without appropriate Personal Protective Equipment? Yes No Unknown

Washing body Preparing body Other direct contact with body/fluids. Specify. _____

Was the person a household member of an EVD patient? Yes No Unknown

Did the person have close contact# with EVD patient? Yes No Unknown

Did the person have direct contact (including care) for EVD patient in household? Yes No Unknown

Did the person directly handle bats, rodents or primates from the Affected Areas**? Yes No Unknown

If Yes, Place of contact. _____ Date of exposure: ____/____/____

Type of animal. Bats Rodents Primates

RISK CLASSIFICATION

- High risk** - check if includes any of the following:
 - Percutaneous (needle stick) or mucous membrane (splashes to eyes, nose, mouth) exposure to blood or body fluids of a symptomatic EVD patient
 - Exposure to blood or body fluids (e.g., feces, saliva, sweat, urine, vomit, semen) of a symptomatic EVD patient **without** appropriate PPE
 - Processing blood or body fluids of a symptomatic EVD patient **without** appropriate PPE or standard biosafety precautions
 - Direct contact with a dead body **without** appropriate PPE in a country **with** widespread EVD transmission
 - Having lived in the immediate household and provided direct care to a symptomatic EVD patient
- Some risk** - check if includes any of the following:
 - In a country **with** widespread EVD transmission: Direct contact with a symptomatic EVD patient **with** appropriate PPE
 - Close contact in households, healthcare facilities, or community settings with a symptomatic EVD patient (*within 3 feet (1 meter) for a prolonged period*)
- Low (but not zero) risk** - check if includes any of the following:
 - In a country **with** widespread EVD transmission within the past 21 days **and** having had no known exposures
 - In any country **without** widespread EVD transmission: Direct contact with a symptomatic EVD patient **with** appropriate PPE
 - Brief direct contact (e.g., *shaking hands*) with an EVD patient in the early stage of disease **without** appropriate PPE
 - Brief proximity (e.g. *being in the same room for a brief period of time*) with a symptomatic EVD patient
 - Traveled on an aircraft with a symptomatic EVD patient
- No identifiable risk**
 - Contact with a healthy person who had contact with a sick EVD patient
 - Contact with an EVD patient before the person developed symptoms
 - A healthy person who was more than 21 days previously in a country with widespread EVD transmission
 - In any country **without** widespread EVD transmission and not having any other exposures as defined above
 - Aircraft or ship crew members who remain on/in the immediate vicinity of the conveyance and have no direct contact with anyone from the community during the entire time that the conveyance is present in a country with widespread Ebola virus transmission

** As of 1/5/15, the affected areas are Guinea, Liberia, and Sierra Leone. Please check CDC.gov/ebola to determine if new areas added.

Close contact : 1) Being within ~3 feet (1 meter) of and EVD patient **OR**

2) Being within the patient's room or care area for a prolonged period of time (e.g., household member, healthcare personnel) while not wearing PPE **OR**

3) Having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing PPE.

NOTE: Brief interactions, such as walking by a person, does NOT constitute close contact

CASE CLASSIFICATION

- Not Case** Specify alternative diagnosis. _____
- Contacts of an EVD Case** – Asymptomatic contacts of an EVD case have different levels of exposure risk (see above).
- Person Under Investigation (PUI)/Suspect Case**
 - Clinical criteria – 1) Fever (subjective fever or measured temperature $\geq 100.4^{\circ}$ F/38°C) **AND**
2) Any of the following: severe headache, fatigue/weakness, muscle pain, vomiting, diarrhea, abdominal pain, **OR** unexplained hemorrhage
- AND**
- An epidemiologic risk factor (see risk classification above) within the past 21 days before the onset of symptoms:
- Confirmed Case** - A case with laboratory confirmed diagnostic evidence of Ebola virus infection.

REMARKS
