



Viral Hemorrhagic Fevers

County _____

Case name (last, first) _____

Birth date ___/___/___ Age at symptom onset _____ Years Months

Alternate name _____

Phone _____ Email _____

Address type Home Mailing Other Temporary Work

Street address _____

City/State/Zip/County _____

Residence type (incl. Homeless) _____ WA resident Yes No

ADMINISTRATIVE

Investigator _____ LHM Case ID (optional) _____

LHM notification date ___/___/___

Classification

Classification pending Confirmed Investigation in progress Not reportable Probable Ruled out Suspect

Investigation status

Complete Complete – not reportable to DOH Unable to complete Reason _____ In progress

Dates: Investigation start ___/___/___ Investigation complete ___/___/___ Record complete ___/___/___ Case complete ___/___/___

REPORT SOURCE

Initial report source _____ LHM _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply) _____

DEMOGRAPHICS

Sex at birth: Female Male Other Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity Hispanic, Latino/a, Latinx Non-Hispanic, Latino/a, Latinx Patient declined to respond Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race Amer Ind/AK Native (**specify:** Amer Ind **and/or** AK Native) Asian Black or African American Native HI/Pacific Islander (**specify:** Native HI **and/or** Pacific Islander) White Patient declined to respond Unk

Additional race information:

- Afghan Afro-Caribbean Arab Asian Indian Bamar/Burman/Burmese Bangladeshi Bhutanese
- Central American Cham Chicano/a or Chicanx Chinese Congolese Cuban Dominican Egyptian
- Eritrean Ethiopian Fijian Filipino First Nations Guamanian or Chamorro Hmong/Mong
- Indigenous-Latino/a or Indigenous-Latinx Indonesian Iranian Iraqi Japanese Jordanian Karen
- Kenyan Khmer/Cambodian Korean Kuwaiti Lao Lebanese Malaysian Marshallese Mestizo
- Mexican/Mexican American Middle Eastern Mien Moroccan Nepalese North African Oromo
- Pakistani Puerto Rican Romanian/Rumanian Russian Samoan Saudi Arabian Somali
- South African South American Syrian Taiwanese Thai Tongan Ugandan Ukrainian
- Vietnamese Yemeni Other: _____

What is your (your child's) preferred language? Check one:

- Amharic Arabic Balochi/Baluchi Burmese Cantonese Chinese (unspecified) Chamorro Chuukese
- Dari English Farsi/Persian Fijian Filipino/Pilipino French German Hindi Hmong Japanese
- Karen Khmer/Cambodian Kinyarwanda Korean Kosraean Lao Mandarin Marshallese Mixteco
- Nepali Oromo Panjabi/Punjabi Pashto Portuguese Romanian/Rumanian Russian Samoan
- Sign languages Somali Spanish/Castilian Swahili/Kiswahili Tagalog Tamil Telugu Thai Tigrinya
- Ukrainian Urdu Vietnamese Other language: _____ Patient declined to respond Unknown

Interpreter needed Yes No Unk

EMPLOYMENT AND SCHOOL

Employed Yes No Unk Occupation _____ Industry _____
 Employer _____ Work site _____ City _____

Student/Day care Yes No Unk
 Type of school Preschool/day care K-12 College Graduate School Vocational Online Other
 School name _____ School address _____
 City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____
 OK to talk to patient (If Later, provide date) Yes Later ___/___/___ Never
 Date of interview attempt ___/___/___ Complete Partial Unable to reach Patient could not be interviewed
 Alternate contact: Parent/Guardian Spouse/Partner Friend Other _____
 Name _____ Phone _____
 Outbreak related Yes No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Complainant ill Yes No Unk Symptom Onset ___/___/___ Derived Diagnosis date ___/___/___
 Illness duration _____ Days Weeks Months Years Illness is still ongoing Yes No Unk

Disease (report dengue, hantavirus or Yellow fever on their respective forms)

Crimean-Congo hemorrhagic fever virus Ebola Guanarito virus Junin virus Lujo virus
 Machupo virus Marburg virus Sabia virus

Clinical Features

Y N Unk

Any fever, subjective or measured Temp measured? Yes No Highest measured temp _____°F
 Fever onset date ___/___/___

Abdominal pain or cramps

Chest pain

Myalgia (muscle aches or pain)

Pharyngitis (sore throat)

Diarrhea (3 or more loose stools within a 24 hour period) Onset date ___/___/___

Nausea

Vomiting Onset date ___/___/___

Rash Type Maculopapular Petechial **Eschar** Other _____
 Description _____ Location _____

Severe headache

Unexplained bleeding (e.g., petechiae, bruises) Describe _____

Proteinuria

Evidence of organ failure (liver, kidney, CNS)

Took malaria chemoprophylaxis

Other final diagnosis established _____

Hospitalization

Y N Unk

Hospitalized at least overnight for this illness Facility name _____
 Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____

Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___

Mechanical ventilation or intubation required

Still hospitalized As of ___/___/___

Y N Unk

Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*

Autopsy performed

Death certificate lists disease as a cause of death or a significant contributing condition

Vaccination

Y N Unk

- Ebola virus vaccine
- Pre-travel typhoid vaccine
- Pre-travel yellow fever vaccine

Vaccine information available Yes No

Date of vaccine administration ___/___/___ Vaccine administered (Type) _____

Vaccine lot number _____ Administering provider _____

Date of vaccine administration ___/___/___ Vaccine administered (Type) _____

Vaccine lot number _____ Administering provider _____

Clinical testing

Creatinine level _____

Hgb/Hct _____

PT/PTT _____

Y N Unk

- Elevated AST or ALT values
- Thrombocytopenia

RISK AND RESPONSE (Ask about exposures 2-21 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____	_____	_____
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Risk and Exposure Information

Y N Unk

- Is case a recent foreign arrival (e.g., immigrant, refugee, adoptee, visitor) Country _____
 - Exposure to semen from a VHF case who recovered from VHF in the past year
 - Exposed to any bats, wild animals, laboratory animals, or bush meat from endemic area
 - Contact with blood or other body fluids of a patient with VHF in the past 3 weeks
- If any known exposure, date of first exposure ___/___/___ Date of last exposure ___/___/___

High Risk

Y N Unk

- Direct contact with dead body in highly affected area without PPE
- Direct skin contact with body fluids or excreta of VHF case without PPE
- Percutaneous or mucous membrane exposure to blood/body fluids (blood, urine, vomit, feces, sweat, semen, breast milk) of VHF case
- Processing VHF specimen without PPE or Laboratory biosafety

Some Risk

- Close contact with symptomatic VHF case in household, healthcare, or other setting (prolonged time within 3 feet) without PPE
 - Direct contact with dead body with PPE
 - Direct patient contact with appropriate PPE in highly affected area
- Describe PPE _____

Low Risk

Y N Unk

- Brief contact or proximity to VHF case without PPE
- In area not highly affected: direct contact with PPE with symptomatic VHF case
- Travel or residence in highly affected area
- Exposures during travel: health care
- Exposures during travel: lab work
- Exposures during travel: care for ill person
- Exposures during travel: animal or bush meat contact
- Other _____
- Shared transport with symptomatic case

Overall risk assessment High Some Low

Exposure and Transmission Summary

Likely geographic region of exposure In Washington – county _____ Other state _____
 Not in US - country _____ Unk

International travel related During entire exposure period During part of exposure period No international travel

Suspected exposure type Animal related Vectorborne Person to person Sexual Blood products IDU
 Health care associated Unk Other _____

Describe _____

Suspected exposure setting Day care/Childcare School (not college) Doctor's office Hospital ward Hospital ER
 Hospital outpatient facility Home Work College Military Correctional facility Place of worship
 Laboratory Long term care facility Homeless/shelter International travel Out of state travel Transit
 Social event Large public gathering Restaurant Hotel/motel/hostel Other _____

Describe _____

Exposure summary

Suspected transmission type (check all that apply) Person to person Sexual Blood products IDU
 Health care associated Unk Other _____

Describe _____

Suspected transmission setting (check all that apply) Day care/Childcare School (not college) Doctor's office
 Hospital ward Hospital ER Hospital outpatient facility Home Work College Military
 Correctional facility Place of worship Laboratory Long term care facility Homeless/shelter
 International travel Out of state travel Transit Social event Large public gathering Restaurant
 Hotel/motel/hostel Other _____

Describe _____

Public Health Issues

Y N Unk

- Case donated blood products, organs or tissue
- Could have exposed others while symptomatic Date (record all) ___/___/___ Location _____
- Health care/EMS
- Home
- Travel
- Other _____
- Contact with mammals while symptomatic Type (record all) _____

Public Health Interventions/Actions

Y N Unk

- Monitor contacts daily for 21 days
- Health care/EMS
- Home
- Travel
- Other contacts _____
- Isolation precautions in health care setting
- Controlled movement in community
- Letter sent Date ___/___/___ Batch date ___/___/___

TRANSMISSION TRACKING

Visited, attended, employed, or volunteered at any public settings while contagious Yes No Unk

Settings and details (check all that apply)

- Day care School Airport Hotel/Motel/Hostel Transit Health care Home Work College
 Military Correctional facility Place of worship International travel Out of state travel LTCF
 Homeless/shelter Social event Large public gathering Restaurant Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

If list of contacts is known, please fill out Contact Tracing Form Question Package

TREATMENT

Y N Unk

Did patient receive prophylaxis/treatment

Specify medication _____ Antibiotic Fungal/Parasitic Antiviral Immune globulin/Antitoxin

Other _____

Number of days actually taken _____ Treatment start date ___/___/___ Treatment end date ___/___/___

Prescribed dose _____ g mg ml Frequency _____ Duration _____ Days Weeks Months

Indication PEP PrEP Treatment for disease Incidental Other _____

Did patient take medication as prescribed Yes No - Why not _____ Unk

Prescribing provider _____

NOTES

Empty space for notes.

LAB RESULTSLab report information**Lab report reviewed – LHJ**

WDRS user-entered lab report note _____

Submitter _____

Performing lab for entire report _____

Referring lab _____

Specimen**Specimen identifier/accession number** _____**Specimen collection date** ___/___/___ **Specimen received date** ___/___/___**WDRS specimen type** _____

WDRS specimen source site _____

WDRS specimen reject reason _____

Test performed and result**WDRS test performed** _____**WDRS test result, coded** _____

WDRS test result, comparator _____

WDRS result, numeric only (enter only if given, including as necessary **Comparator** and **Unit of measure**) _____

WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

WDRS result summary Positive Negative Indeterminate Equivocal Test not performed PendingTest result status Final results; Can only be changed with a corrected result Preliminary results Record coming over is a correction and thus replaces a final result Results cannot be obtained for this observation Specimen in lab; results pending

Result date ___/___/___

Upload documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.